DOCTORS
MEDICAL CENTER

Doctors Medical Center Management Authority, JPA BOARD

Wednesday, April 28, 2010
3:00 PM – Auditorium
Doctors Medical Center
2000 Vale Road
San Pablo, CA

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY

Doctors Medical Center Management Authority,
JPA Board
Wednesday, April 28, 2010 – 3:00 pm
Doctors Medical Center - Auditorium
2000 Vale Road, San Pablo, CA 94806

Governing Board
Supervisor John Gioia, Chair
Stephen Arnold, M.D.
Pat Godley
Supervisor Federal Glover
Bill Walker, M.D.
Beverly Wallace
Eric Zell

AGENDA

1. Call to Order and Roll Call

2. Approve Minutes of Board Meeting of March 24, 2010

3. Public Comment
   [At this time persons in the audience may speak on any items not on the Agenda which are within the jurisdiction of the Doctors Medical Center Management Authority.]

4. Quality Report

5. Presentation and Acceptance of the March 2010 Financial Statements

6. Ingram & Associates: *Approve and authorize CFO to execute on behalf of DMC a contract with vendor to provide self pay collection services*

7. Keenan & Associates: *Approve and authorize the CFO to executive on behalf of DMC, a two year extension to the agreement and provide employee benefit consulting services*

8. Medco Health Solutions: *Recommendation to the District Board to approve contract with vendor for employee pharmacy benefit*

9. Moss Adams, LLP – Audit Report

10. CEO Report

Closed Session

11. Conference with Labor Negotiators (pursuant to Government Code Section 554957.6) Agency Negotiators: Lydia Chan, Director of Labor Relations Employee Organizations: California Nurse Association

Open Session

12. Report of Reportable Action(s) Taken During Closed Session, if any.

13. Adjournment

DOCTORS
MEDICAL CENTER

MINUTES – 3/24/10

Tab 2

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY

Doctors Medical Center Management Authority
Governing Board Meeting
March 24, 2010 – 3:00 pm
Doctors Medical Center - Auditorium
2000 Vale Road, San Pablo, CA 94806

Governing Board
Supervisor John Gioia, Chair
Stephen Arnold, M.D.
Pat Godley
Supervisor Federal D. Glover
Bill Walker, M.D.
Beverly Wallace
Eric Zell

Minutes

1. **Call to Order and Roll Call – 3:05 p.m.**

   Quorum was established; roll was called.

   Voting Members: *Supervisor John Gioia, Chair*
   Beverly Wallace
   Stephen Arnold, M.D.
   Bill Walker, M.D.
   Eric Zell

   Excused Absence: *Supervisor Federal D. Glover*
   Pat Godley

2. **Approval Minutes of Board Meeting of February 24, 2010**

   The motion made by Mr. Zell and seconded by Ms. Wallace to approve the minutes of the February 24, 2010 Board meeting passed unanimously.

3. **Public Comment**

   There were no public comments.

4. **Presentation and Acceptance of February 2010 Financial Statements**

   Richard Reid, CFO, reported February 2010 net income was a gain of $852,000 on a budget of $887,000; case mix adjusted average length of stay decreased to 3.61 days and the average daily census was 116. He reported that the total cash balance is $6.2 million and there are 15 days of cash on hand.

   Mr. Reid provided the Board with a two-year trend of the RN overtime from 2008-January 2010. The data showed a savings of over $2 million after conversion from the 12-hour shift to the 8-hour shift.

   On April 21st, Mr. Reid and David Ziolkowski, COO, will be holding ongoing operational performance meetings with Directors starting on April 21st to look at revenue and expenditure variances and plan of action to bring it back to budget.

Mr. Reid will also set goals to reduce days in accounts receivable and bring the information back to the board.

Mr. Reid indicated that the auditors are suggesting that we focus on credit balances on patient accounts this year.

The motion made by Dr. Walker and seconded by Ms. Wallace to accept the financials for February 2010 passed unanimously.

5. **Approval of New Policy Regarding Delegation of Authority to CEO Pursuant to JPA Agreement, Article 9. Management Oversight of DMC, Section 2: Personnel and Employment Policies and Procedures.**

A motion was made by Ms. Wallace and seconded by Mr. Zell to approve new policy regarding delegation of authority to CEO pursuant to JPA Agreement, Article 9. Management Oversight of DMC, Section 2: Personnel and Employment Policies and Procedures. The motion passed unanimously.

This new policy delegates authority to CEO for oversight of personnel decisions involving members of DMC's executive team to the CEO, including hiring and termination. The CEO will consult with the Authority Board or a committee thereof in connection with hiring of vice-president.

6. **Quality Report**

George Wenner, Quality Director, reported that ORYX data is published on the Joint Commission extra net and not open to the public domain. Following is a summary of core measures for the 3rd quarter that has been reported and published where DMC has demonstrated areas of improvement:

- Antibiotic administered within 1 hour of incision
- Discontinuance of antibiotic within 24 hours
- Completed Discharge Instructions for Health Failure Patients
- Seasonal Influenza vaccine administration

He also presented Nursing Regulatory Compliance from January-March 2010. A scorecard for each core measure is provided. The nursing directors review 30 patient charts every month to generate these scorecards.

A Hospital-wide Performance Improvement Committee was established and will be meeting starting in April 2010. The composition is multidisciplinary and will include staff as well as board membership. The area listed, as improvements are indeed areas of non-compliance at least 2 standard deviation from the average for 3 or more quarters. Those listed have an intensive review and these are the action plan items.

7. **CEO Report**

Joseph Stewart, President/CEO, gave the following update:

- Relocation of County Clinic to DMC Site – Meetings have occurred but still no response to the District Board's requests. The following logistics are still to be resolved before a decision to proceed is made:
  - Parking
  - Traffic volume (studies are being conducted on traffic impact of this relocation)
  - Lease terms for the land (need to establish land value and lease amount/year)
  - The impact of the clinic on hospital volume and services such as imaging and laboratory
  - Impact to ER (if there are 250 patients w/ county clinic, what happens after hours)

A meeting has been requested by the hospital with Archer Norris and the County representatives as soon as the parking analysis is done.

- The Outpatient Clinic construction has begun. The anticipated opening date is early July 2010.

- The Emergency Department can now provide patient care to stroke patients at DMC through the neurology telemedicine that will connect directly to a neurologist at CPMC.

- The installation of Midas Quality Software has been completed and trial runs of the system are underway.

8. <u>Adjourn to Closed Session</u>

The JPA Board adjourned to closed session at 3:44 p.m. There were no reportable actions taken in closed session.

DOCTORS MEDICAL CENTER

QUALITY REPORT

Tab 4

DOCTORS MEDICAL CENTER
DEPARTMENTAL SPECIFIC PERFORMANCE IMPROVEMENT PLAN
2010

Department:

Responsible person for plan oversight:

Overview of department plan on hospital-wide
Performance improvement:

Performance Improvement Activities:

Description:

Numerator/Denominator

Collection methodology

Reporting schedule

Expected performance measure (goal)

Reporting Analysis will include the numerator/denominator results in a percentage format. Areas of success, areas of needed improvement and actions to be take to achieve increased performance.

Hospital Acquired Conditions

1st Qtr 2009

Code	Description	Number of Cases	Rate of hospital acquired	N/D
800	Fractures	40	0%	0/34
707.23	Pressure Ulcer Stage 3	22	4.5%	1/22
707.24	Pressure Ulcer Stage 4	10	0%	0/10
250.10	Manifestation of Poor Glycemic Control	8	0%	0/8
850	Intracranial Injury	4	0%	0/4
991	Electric Shock	1	0%	0/1

2nd Qtr 2009

Code	Description	Number of Cases	Rate of hospital acquired	N/D
800	Fractures	29	0%	0/29
707.23	Pressure Ulcer Stage 3	14	7.1%	1/14
707.24	Pressure Ulcer Stage 4	2	0%	0/2
250.10	Manifestation of Poor Glycemic Control	4	0%	0/4
850	Intracranial Injury	2	0%	0/2
830	Dislocation	1	0%	0/1
999.31	Vascular Catheter Associated Infection	1	0%	0/1

3rd Qtr 2009

Code	Description	Number of Cases	Rate of hospital acquired	N/D
800	Fracture	24	0%	0/24
707.23	Pressure Ulcer Stage 3	13	0%	0/13
707.24	Pressure Ulcer Stage 4	12	0%	0/12

250.10	Manifestation of Poor Glycemic Control	3	0%	0/3
999.31	Vascular Catheter Associated Infection	1	0%	0/1

4th Quarter 2009

Code	Description	Number of Cases	Rate of hospital acquired	N/D
800	Fracture	40	0%	0/40
707.23	Pressure Ulcer Stage 3	23	8.7%	2/23
707.24	Pressure Ulcer Stage 4	10	0%	0/10
250.10	Manifestation of Poor Glycemic Control	11	9.1%	1/11
999.31	Vascular Catheter Associated Infection	2	0%	0/2
991	Electric Shock	1	0%	0/1
830	Dislocation	1	0%	0/1
850	Intracranial Injury	1	0%	0/1

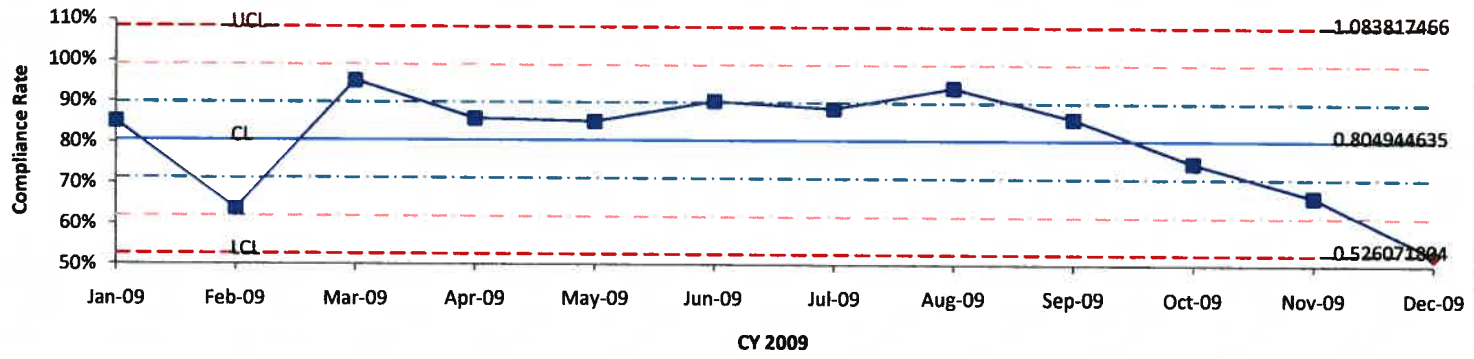
Analysis for 2009

There were a total of 274 complication codes noted in 2009 of which the Centers for Medicare and Medicaid Services consider "Never Events" of which 5 were not documented at the time of admission which classifies them as hospital acquired. Of the 5 events 4 were pressure ulcers stage 3 and 1 case of poor blood glucose control. There were identified trends of the never events noted in this review.

Core Measures:
Appropriateness of Care Compliance

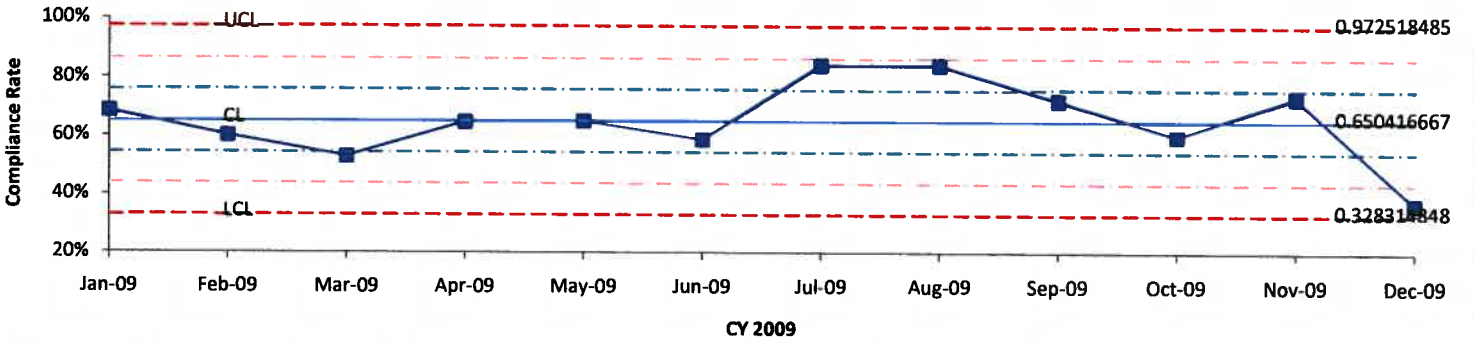
DOCTORS MEDICAL CENTER

AMI (Heart Attack)- Patient Appropriateness of Care Compliance



Analysis and Action:	Level of Risk/Concern
Top 10% of hospitals have 100 % Compliance, National average is 95%. Total AMI Cases: Num 141/ Den 176	

PNA (Pneumonia) - Appropriateness of Care

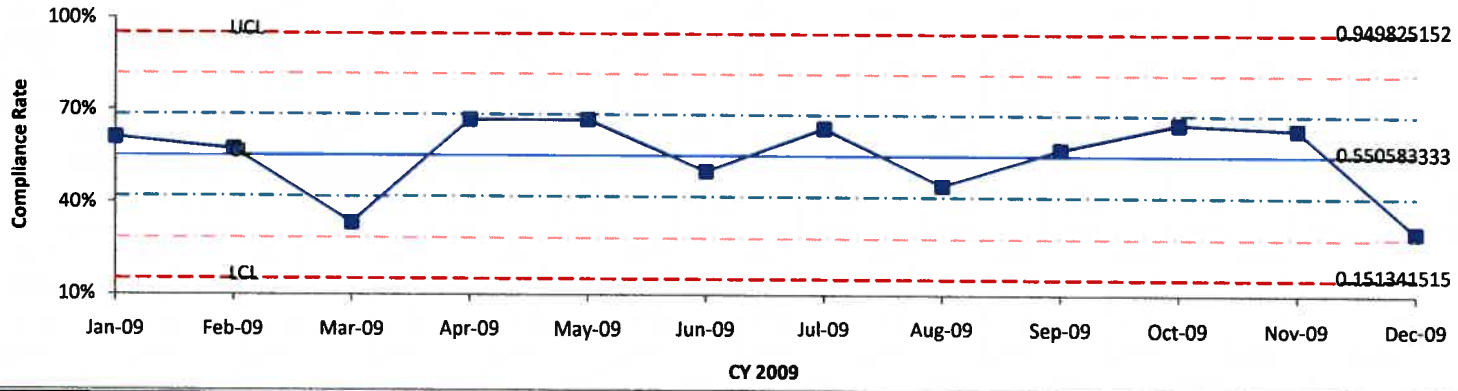


Analysis and Action:	Level of Risk/Concern
Top 10% of hospitals have 99% compliance while the national average is 91% Total PNA Cases: Num 34/ Den 56	

Core Measures:
Appropriateness of Care Compliance

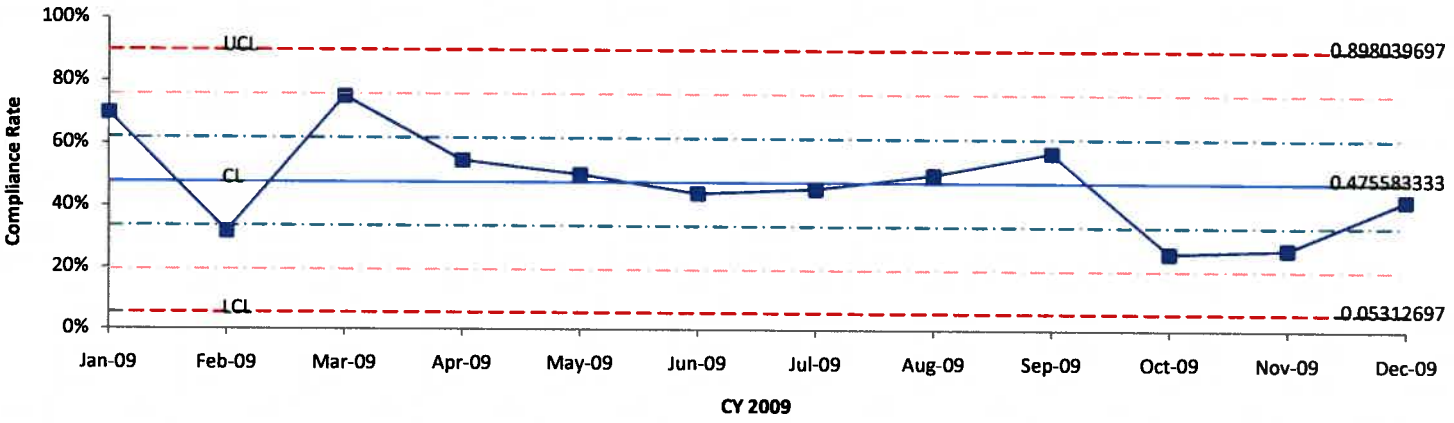
DOCTORS MEDICAL CENTER

CHF (Heart Failure)- Appropriateness of Care



Analysis and Action:	Level of Risk/Concern
Top 10% of hospitals have 100% compliance while the national average is 95%. Total CHF Cases: Num 33/ Den 65	

SCIP (Surgical Infection Prevention)- Appropriateness of Care



Analysis and Action:	Summary:
Top 10% of hospitals are at 100% compliance while the national average is 97%. Total SCIP Cases: Num 37/ Den 62	

DOCTORS
MEDICAL CENTER

FINANCIALS
MARCH 2010

Tab 5

DOCTORS MEDICAL CENTER

March 2010 Executive Report

Doctors Medical Center had a Net Income of $1,238,000 in the month of March. As a result, net income was under budget by $516,000 due to higher self pay inpatient volume and lower net outpatient patient service revenue.

On a year to date basis, Doctors Medical Center has net income of $2.4 million on a budget of $3.3 million.

The following are the factors leading to the March 2010 Net Income variance:

Net Income Factors	**Over / (Under)**
Net Patient Revenue	
Self Pay Inpatient Volume	($507,000)
Outpatient Volume	($522,000)
All Other Inpatient Volume	$687,000
Expenses	
Salaries	($573,000)
Supplies	($101,000)

Net patient revenue was under budget by $342,000. Gross outpatient charges were under budget in March 8.2%. Patient days were 8.8% over budget and discharges were 7.8% over budget. The inpatient volume increase was in Self Pay $507,000 which is a negative since these accounts are largely bad debt. The rest of the inpatient volume was positive and mixed among all the other inpatient payers. Outpatient gross charges were under budget by $1,716,000 which created negative net patient revenue from outpatient services of $522,000.

Salaries were over budget by $573,000. We received late billings for registry staff in March for the month of January for $185,000. The balance of the overage is a reflection of the inpatient census that was over budget by 8.8%.

Supplies were over budget by $101,000 in March. The increase was for surgical implants which were $151,000 over budget. Costs were under budget in pacemakers in the Cath Lab offsetting part of the overage. This variance is directly related to volume.

Because of the $ 2 million variance in Operating Loss from Budget, Management has implemented 3 teams to develop an action plan to recover the budget variance. These teams will look at revenue enhancement opportunities, salary costs and other costs. The teams will be chaired by the CFO and supported by the COO. The results of the action plans will be reported to the JPA and District Boards at all upcoming meetings.

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
March 31, 2010
(Amounts in $1,000)

		Current Month	Dec. 31, 2009
	ASSETS		
67	Cash	9,476	7,666
68	Net Patient Accounts Receivable	21,413	19,157
69	Other Receivables	6,288	5,367
70	Inventory	2,131	2,056
71	Prepaid Expenses and Deposits	1,034	610
72	**TOTAL CURRENT ASSETS**	**40,342**	**34,856**
73	**Assets With Limited Use**	**4,249**	**5,363**
	Property Plant & Equipment		
74	Land	12,090	12,090
75	Bldg/Leasehold Improvements	34,390	34,390
76	Capital Leases	10,926	10,926
77	Equipment	32,961	32,889
78	CIP	2,276	1,281
79	Total Property, Plant & Equipment	92,643	91,576
80	Accumulated Depreciation	-48,400	-47,543
81	**Net Property, Plant & Equipment**	**44,243**	**44,033**
82	**Intangible Assets**	**575**	**586**
83	**Total Assets**	**89,409**	**84,838**
84	Current Ratio (CA/CL)	***1.15***	***1.09***
85	Net Working Capital (CA-CL)	***5,256***	***2,951***
86	Long Term Debt Ratio (LTD/TA)	***0.27***	***0.30***
87	Long Term Debt to Capital (LTD/(LTD+TE)	***0.46***	***0.49***
88	Financial Leverage (TA/TE)	***3.2***	***3.3***
89	Quick Ratio	**0.88**	**0.84**
90	Unrestricted Cash Days	**23**	**21**
91	Restricted Cash Days	**10**	**14**
92	Net A/R Days	**62.8**	**62.3**

		Current Month	Dec. 31, 2009
	LIABILITIES		
93	Current Maturities of Debt Borrowings	3,676	3,634
94	Accounts Payable and Accrued Expenses	14,858	11,827
95	Accrued Payroll and Related Liabilities	10,229	9,403
96	Deferred District Tax Revenue	2,724	3,570
97	Estimated Third Party Payor Settlements	3,599	3,471
98	**Total Current Liabilities**	**35,086**	**31,905**
	Other Liabilities		
99	Other Deferred Liabilities	0	0
100	Chapter 9 Bankruptcy	1,771	1,771
	Long Term Debt		
101	Notes Payable - Secured	25,395	25,966
102	Capital Leases	2,547	2,973
103	Less Current Portion LTD	-3,676	-3,633
104	**Total Long Term Debt**	**24,266**	**25,306**
105	**Total Liabilities**	**61,123**	**58,982**
	EQUITY		
106	Retained Earnings	25,855	14,807
107	Year to Date Profit / (Loss)	2,431	11,049
108	**Total Equity**	**28,286**	**25,856**
109	**Total Liabilities & Equity**	**89,409**	**84,838**

DOCTORS MEDICAL CENTER

INGRAM AND ASSOCIATES: SELF PAY COLLECTION SERVICES

Tab 6

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY
AGENDA ITEM REQUEST / RECOMMENDATION
DOCUMENTATION FORM

TO: **DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY**

FROM: **Richard S. Reid, CFO**

DATE: **April 28, 2010**

SUBJECT: Self Pay Collection Agency

REQUEST / RECOMMENDATION(S): Approve and authorize the Chief Financial Officer, to execute on behalf of DMC, a contract with Ingram & Associates to provide self pay collection services at a rate of 9%.

FISCAL IMPACT: Estimated annual costs of $90,000 with additional cash collections of $1,000,000.

STRATEGIC IMPACT: This contract is important to DMC due to the low volume of collections from the self pay population. This agreement will bring sophisticated process and tools to improve collections.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION:

Presentation Attachments: Yes _X_ No ____

Requesting Signature: Richard S Reid Date: 4/22/10

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____
Vote of Board Members:

_____ Unanimous (Absent_____)
Ayes: _____ Noes: _____
Absent: _____ Abstain: _____

I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person: Richard Reid

Attested _____
Eric Zell, Management Authority Board Secretary

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

DOCTORS MEDICAL CENTER

Self Pay Solution Plan

Components of Self Pay Accounts Receivable

- True Self Pay - (Uninsured)
- Medi-Cal pending
- Patient pay portion of insurance

True Self Pay

- Currently DMC has Discounted Rates
  - Inpatient - $1,000 per day
  - Outpatient - 75% off charges
  - Emergency Department - flat rates based on level of service provided

Self Pay Current Process

- Worked by Internal Staff after they leave
  - Some follow up done by internal staff -Focused on Inpatients
  - Statements sent at 30, 60 and 90 days by McKesson
  - Cost approximately $4,000 per month annual cost $48,000
  - At 120 Days transferred to Bad Debt Agency
  - Worked by agency at cost of 20-25% of collections

New Process

- No Staff Deductions
- Working with Local One on this process
- At DMC – Worked by Internal Staff
- After they leave
  - DMC Staff work Inpatients accounts for specific amount of time
  - Worked by Extended Business Office with Automated Telephone and dedicated Staff
  - Statements sent by Extended Business Office
  - At 120 Days – Sent to Bad Debt Agent
  - Worked by Bad Debt Collection Agency

Extended Business Office

- Onsite interviews with 3 companies
- Recommending to contract with Ingram & Associates
- Have sophisticated collections software and equipment
- Have access to our patient automated systems and all collection activity is recorded in our system
- Rate 9% of collections

Process for Selection

- Received 8 outside bids
- Internal team from Patient Financial Services reviewed proposals, did interviews
- Director checked references
- Full disclosure to Local One. Shop Steward is a member of the Internal Team.
- Will select within next few weeks
- Proposed start June 30

Medi-Cal Pending

- Current Vendor – Diversified
- Conversion rate approximately 65%
- Diversified will be involved in implementation of Extended Business Office. This will ensure the flow is efficient and effective
- This process works – no changes proposed

After Insurance Patient Payment

- Currently have limited up front payments
- Issue – can not accurately determine patient portion of pay
- Complex calculation involing:
  - Insurance contract
  - Information at Insurance Computer System
  - History of prior payments
  - Need automation to assist

Automated System

- RECONDO System
- Links hospital contracts with insurance companies information
- Real time estimate of patient portion
- Real time eligibility with hits to major insurance carriers, payment if insurance is unknown
- Available to do soft credit check if needed
- Web based
- Cost $7,950 per month at month 5. Graduated payment up to month 5.

Increased Annual Collection Goals

1. Self Pay	1.0 million
2. Medi-Cal	-0-
3. After insurance	1.5 million
Increased Annual Collection Goal	2.5 million
Current Goal	1.0 million
Total Annual Collection Goal	3.5 million

Additional Annual Cost

Self Pay	$ 90,000
Medi-Cal Pending	-0-
After Insurance	$ 95,400
Total	$185,400

Annual Budget Impact

Total Additional Cost		$185,400
Patient Statements	60,000	
Current Eligibility Software	24,000	
Reduction in Current Expenses		$<84,000 >
Net Increase in Cost		$101,400

Financial Summary

Additional Revenue	$2, 500,000
Less Additional Cost	- 101,400
Net Increase in annual income	$2, 398,600

Request

- To approve the Self Pay Plan and to authorize the Chief Financial Officer to contract with an Ingram & Associates for Self Pay collections at a rate of 9%.

INGRAM & ASSOCIATES, LLC
SERVICES AGREEMENT

This Services Agreement ("Agreement") made and entered into this 22nd day of April 2010, is by and between: Doctors Medical Center, having its principle office at San Pablo Campus, 2000 Vale Road, San Pablo, CA 94806, ("Client"): and **Ingram & Associates, LLC,** a limited liability company, and having its principle office at 1720 General George Patton Drive, Brentwood, Tennessee, 37027, ("Consultant").

WITNESSETH

For and in consideration of the mutual covenants and promises contained herein the sufficiency of which is conclusively acknowledged, the parties do hereby contract and agree as follows:

ARTICLE 1 – SERVICES

(1.1) **Services of Consultant.** When Client agrees to purchase and Consultant agrees to provide Services to Client under this Agreement, the parties shall sign appropriate product Schedules ("Schedules") to this Agreement. Each Schedule shall define the Services (the "Services") to be provided to Client and the prices and terms applicable to them. To the extent the terms of a Schedule conflict with the terms of this Services Agreement, the terms of the Schedule shall control. Client shall have the right to receive and use only the Services specified on a signed Schedule, and shall have no other rights or licenses to Consultant's services (except as provided in any other signed agreement between Client and Consultant

(1.2) **Included Accounts.** Client shall provide Consultant with access to and Consultant shall perform Services and receive compensation with respect to all of Client's existing and future accounts assigned to Consultant pursuant to the terms and conditions of this Agreement. Included accounts shall be identified on the applicable Schedule.

ARTICLE 2 – PRICING

(2.1) **Consultant Compensation.** As compensation for Services rendered under this Agreement, Client agrees to pay fees to Consultant pursuant to the pricing contained in the Schedule for all Services provided by Consultant, including out-of-pocket expenses as incurred.

(2.2) **Contingency Fees.** With respect only to contingency fee services, Client shall be responsible for the timely entry of all payments for accounts collected by Consultant. Consultant shall adjust any and all fees paid by Client under this alternate billing method upon receipt of and reconciliation of the actual payment data received from Client for each such invoicing period.

(2.3) **Payment of Invoices.** Client will pay all invoices from Consultant within thirty (30) days of each invoice date. A one and one half (1.5) percent finance charge will be assessed on all invoices greater than thirty (30) days outstanding from the receipt date of invoice.

ARTICLE 3 – LIMITATION OF LIABILITY AND INDEMNIFICATION

(3.1) Consultant agrees to defend, indemnify and hold Client harmless from and against any third party claims arising out of Consultant's breach of this Agreement. In addition, Client agrees to indemnify and hold Consultant harmless from and against any third party claims solely arising out of Client's breach of this Agreement.

(3.2) Each party's liability to the other for direct damages arising out of this Agreement shall not exceed the amount Client has paid or owes Consultant for the 12-month period immediately prior to the incident giving rise to the cause of action. Neither party shall be responsible under this Agreement for any indirect, incidental, special or consequential damages resulting from either party's performance or failure to perform under this Agreement. This section 3.2 does not limit the parties obligations to each other under section 3.1 or Client's liability to Consultant for failure to pay amounts due under this Agreement.

ARTICLE 4 – CONFIDENTIALITY AND NONDISCLOSURE

(4.1) **Consultant Obligations.** Consultant will keep confidential any information relating to Client's business, which is confidential and is solely designated in writing to be so. Consultant shall have the right to compile and distribute aggregate statistical analyses and reports utilizing data derived from information and data from Client and other Consultant customers and other sources.

(4.2) **Client's Obligations.** Client will keep confidential any information relating to Consultant's business, which is confidential and is clearly designated in writing to be so and will instruct its employees and agents to keep such information confidential by using the same care and discretion that they use with similar data, which Client designates as confidential.

(4.3) **Exceptions.** Nothing in this Agreement shall be construed to restrict disclosure or use of information that (a) was in the possession of or rightfully known by the recipient, without an obligation to maintain its confidentiality, prior to receipt from the other party; (b) is or becomes generally known to the public without violation of this Agreement; (c) is obtained by the recipient in good faith from a third party having the right to disclose it without an obligation of confidentiality; or (d) is independently developed by the receiving part without reference to the other party's Confidential Information.

ARTICLE 5 – REPRESENTATIONS AND WARRANTIES

(5.1) **Consultant Representations.** Consultant represents and warrants that the Services will be performed in a professional manner. Consultant shall observe and comply with applicable State and Federal law concerning patient privacy rights.

(5.2) **Client Representations.** Client represents warrants and agrees that it will use its best efforts to assure that all information provided Consultant in order to perform the Services shall be true and correct. Client authorizes Consultant to transmit patient information and records to insurers and other third party payors to accomplish its responsibilities as set forth in this agreement. Client is responsible for obtaining, prior to furnishing any data or information to Consultant, any necessary permissions, consents, or releases, including entering into business associate agreements as applicable, which are required by applicable federal, state or local laws and/or regulations for the delivery of data to Consultant and for Consultant to use and disclose such data as set forth under this Agreement or required by law.

(5.3) Except as expressly provided in this Agreement, CONSULTANT MAKE NO WARRANTIES OR REPRESENTATIONS RELATING TO THE SERVICES, EXPRESS OR IMPLIED, AND SPECIFICALLY DISCLAIMS THE WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE

ARTICLE 6 – TERM

(6.1) **Term.** This Agreement commences as of the Effective Date and continues for an initial term of thirty-six (36) months ("Initial Term") unless otherwise specified in the Schedule.

(6.2) **Payment of Sums Outstanding.** Upon termination of this Agreement for any reason by either party, all amounts due and payable under this Agreement but not yet paid by Client shall immediately be due and payable in full and shall be paid by Client to Consultant within thirty (30) days of the effective date of termination.

(6.3) **Termination.** Either party may elect not to renew this Agreement by giving the other party written notice of its intent not to renew at least ninety (90) days prior to the end of the Initial Term or any subsequent Renewal Term. Additionally, this Agreement may be terminated by either party upon the other party's failure to cure a material breach of this Agreement, within 60 days of receipt of written notice describing the nature of the alleged material breach, including nonpayment of any fees when due. Upon receipt of notice of termination by either party all rights and duties of the parties pursuant to this Agreement shall continue during the notice period. Upon termination of this Agreement Consultant will close and return all accounts to Client.

ARTICLE 7 – DEFAULT

(7.1) **Defaults.** The occurrence of any of the following shall constitute an event of default under this Agreement.

a) If a party ceases to do business, becomes insolvent, commences a case or files an application seeking any type of relief under the federal bankruptcy laws.

b) If a party fails to observe or perform any material non-monetary obligation under this Agreement and fails to take action and to remedy any such breach within sixty (60) days after written notice is provided thereof to the other party.

c) If a party fails to pay any amounts due under this Agreement and fails to pay for a period of thirty (30) days after receipt of written notice thereof.

ARTICLE 8 – MISCELLANEOUS

(8.1) **Excusable Delay.** Neither Consultant nor Client shall be liable under this Agreement for any delay or failure to perform for any cause beyond the party's reasonable control, whether foreseeable or not. Consultant and Client agree that upon the occurrence of any of the foregoing, they shall deal with each other in good faith so as to minimize the losses suffered by each party.

(8.2) **Notices.** Any notice required or permitted to be given under the terms of this Agreement shall be deemed sufficient if in writing and sent by certified mail to the other party at the following addresses:

CONSULTANT:
Ingram & Associates, LLC
1720 General George Patton Drive
Brentwood, TN 37027

With a copy to:
General Counsel
12125 Technology Drive
Eden Prairie, MN 55344

CLIENT:
_____
_____
_____

(8.3) **Severability.** In the event any portion of this Agreement shall be determined to be invalid under any applicable law, such provision shall be deemed void and the remainder of this Agreement shall continue in full force and effect.

This Agreement shall constitute the entire agreement between the parties with respect to the subject matter of this Agreement and shall not be altered, varied, revised or amended, except in writing and signed by both parties. The provisions of this Agreement shall supersede all prior oral or written quotations, communications, agreements and understandings of the parties with respect to the subject matter of this Agreement. Consultant and Client have caused this Agreement to be executed by their duly authorized representatives on the dates set forth below.

Doctors Medical Center		Ingram & Associates, LLC	
By:	_____	By:	_____
Name:	_____	Name:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

Early-out Collection Services & Pricing Schedule

1. Services: Ingram & Associates early-out collection services are provided on a contingency fee arrangement based on cash collected. Under this Schedule, Ingram will take follow-up and collection responsibility for all identified self pay accounts turned over at the sole discretion of Client. Client will place all self pay accounts at day one. Consultant will work these accounts for approximately 120 days from the date of receipt and return accounts not pending payment or in a payment plan to Client at the end of that period. Consultant will follow the collection policies and guidelines of Client.

2. PRICING

2.1 Project Pricing shall be as follows:

2.1.1 Early Out Self Pay Collections Day 1 *8%*

2.2 Fees will be paid for any payments received within 30 days after service or collections efforts cease.

2.3 All fees are based on Consultant receiving the defined time frame of accounts expected, as indicated in this Schedule. If the total amounts placed with Consultant are below those indicated Consultant shall have the right to renegotiate the fees to mutually acceptable rates between Consultant and Client.

2.4 In the event that Client seeks resolution of outstanding reimbursements directly or indirectly with the originating payor/payors, and the result is either a reduced overall payment to Client or a justification against other historical or future charges for services rendered for payor/payors by Client, and the basis for that payment/justification is information or data specifically generated by Consultant for Client, Client agrees to pay Consultant an adjusted fee on the residual outstanding balance reflecting either the percentage of discount against the unrevised total, or the agreed fee against the realized justification payment.

2.5 With respect to both per diem and contingency fee projects, out-of-pocket expenses are the responsibility of Client. Client shall make reimbursement for any routine actual out-of-pocket expenses incurred in rendering consulting services. With respect to on-site resources, this will include but not be limited to travel, car rental, lodging and meal expenses for on-site personnel time, if applicable.

3. Consultant Responsibilities

3.1 Consultant will utilize data electronically transmitted by Client to identify, contact and follow-up and collect on all assigned accounts. Consultant will perform routine account follow-up activities using telephone and/or written communication to third party payors for all accounts as set forth in Exhibit A subject to: (i) all applicable legal restrictions on such activities, and (ii) Client's right to direct Consultant to cease its efforts to contact any such entity.

3.2 Consultant will perform Services until an account has been paid in full, has been deemed uncollectible by Consultant, or Client has instructed Consultant to cease its efforts with respect to such account. If accounts are determined to be uncollectible they will be returned to Client to determine further disposition.

3.3 All payments will be directed to Client.

3.4 Consultant will provide a toll-free telephone number for all telephone patient inquiries relating to assigned accounts. Consultant shall obtain permission from Client prior to contacting any patient in regard to this project.

3.5 Consultant will prepare and render on a monthly basis computer generated management information reports to Client which shall include the following: (1) monthly and year-to-date payment summary information; (2) such

other reports as shall be mutually agreed to by Consultant and Client; (3) feedback/recommendations on contract language upon completion of contract review; (4) feedback/recommendations on Client's managed care strategy.

4. Client Responsibilities

4.1 Client, or its duly authorized agents, will at Client's expense perform the following actions on a timely basis and otherwise comply with the following provisions:

4.2 Client shall electronically transmit to Consultant all accounts set forth in Exhibit A with Consultant for follow-up and collection. Client's patient accounting system will electronically transmit, on a mutually agreed upon schedule, all assigned accounts, payments, and adjustment information to Consultant's receivables management system.

4.3 Client shall maintain accounts receivable management, follow-up and collection policies and practices in full conformity with applicable laws, and respond promptly to all inquiries regarding such policies and practices.

4.4 Client shall assist in training Consultant personnel in carrying out the provisions of this Schedule.

4.5 Client shall grant reasonable access to Consultant and its representatives upon fifteen (15) days prior written notice, to inspect the books and records of Client solely for the purpose of determining compliance with this Agreement.

Doctors Medical Center		Ingram & Associates, LLC	
By:	_____	By:	_____
Name:	_____	Name:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

DOCTORS
MEDICAL CENTER

KEENAN & ASSOCIATES: EMPLOYEE BENEFIT CONSULTING SERVICES

Tab 7

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY
AGENDA ITEM REQUEST / RECOMMENDATION
DOCUMENTATION FORM

TO: **DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY**

FROM: **Richard S. Reid, CFO**

DATE: **April 28, 2010**

SUBJECT: Approval of 2 year extension of the Keenan & Assoicate Contract for Employee Benefit Services.

REQUEST / RECOMMENDATION(S): Approve and authorize the Chief Financial Officer, to execute on behalf of DMC, a two(2) year extention to the agreement with Keenan & Associates to provide employee benefit consulting services.

FISCAL IMPACT: $ 90,000 per year for two (2) years. Total cost is $180,000. These will be paid out of operating budget amounts. This does represent an increase over the budgeted amount of $13,334 per year.

STRATEGIC IMPACT: Keenan & Associates provides employee benefit consulting services to DMC. A listing of accomplishments is attached.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION:

Presentation Attachments: Yes _X_ No ____

Requesting Signature: Richard S Reid Date: 4 / 22 / 10

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____
Vote of Board Members:

_____ Unanimous (Absent_____)
Ayes: _____ Noes: _____
Absent: _____ Abstain: _____

I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person: Richard Reid

Attested _____
Eric Zell, Management Authority Board Secretary

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

AMENDMENT

This Amendment hereby amends the Employee Benefits Consulting Services Agreement ("Agreement") dated April 1, 2009 by and between Keenan & Associates and West Contra Costa Healthcare District dba Doctors' Medical Center San Pablo as follows (hereafter referred to collectively as "Parties"):

WHEREAS, the current term of the Agreement shall expire on April 30, 2010; and

WHEREAS, the Parties desire to continue their relationship subject to the terms and conditions outlined in the Agreement.

NOW, THEREFORE, the parties agree as follows:

1. The Agreement is hereby renewed for an additional two (2) year term beginning on May 1, 2010 and ending on April 30, 2012 ("Renewal Term").

2. The consulting fee for the services rendered under the Agreement for the term of the Agreement shall be $90,000 per year. This fee shall be due and payable in twelve (12) equal installments per year commencing May 1, 2010.

3. All the remaining terms and conditions of the Agreement shall remain unchanged and in full force and effect during, and shall govern the conduct of the Parties during the Renewal Term.

4. The effective date of this amendment is May 1, 2010.

5. Each person signing this Amendment to the Agreement on behalf of a Party represents and warrants that he or she has the necessary authority to bind such Party and that this Amendment is binding on and enforceable against such Party.

West Contra Costa Hospital District d/b/a Doctors' Medical Center		**Keenan & Associates**	
Signature:	_____	**Signature:**	_____
By:	**Joseph A. Stewart**	**By:**	**James D. Tinyo**
Title:	**Chief Executive Officer**	**Title:**	**Senior Vice President**
Address:	**2000 Vale Road** **San Pablo, CA 94806**	**Address:**	**2355 Crenshaw Blvd., Ste. 200** **Torrance, CA 90501**
Attention:	**Joseph A. Stewart**	**Attention:**	**Marie Croco**

Doctors Medical Center
2009 Stewardship Report
May - December

Consulting

- **Strategic Planning –** Discussed Doctor's business environment and its impact on Benefit programs. Discussed 2010 goals and possible plan changes with Senior Management Team.

- **Keenan HealthCare Benefits Survey and Benchmarking** – Conducted the intake and presentation of the 2009 results.

- **Prepared 2010 Funding (Budget) and COBRA Rates**

- **Cost Assessment** - Provided a benefit cost assessment which showed Doctor's benefit programs compared to the San Francisco market and discussed potential opportunities.

- **Discussed Possible 2010 Plan Changes:**

    - **Mental Health Parity** – Reviewed medical plan and presented Mental Health Parity modifications for 2010 plan year.
    - **Enrollment** – allow employees to enroll in M/D/V plans separately.
    - **Reduce Waive Credit for New Hires**
    - **Change to cost effective carriers ASAP**

- **Dependent Audit Presentation** – Presented proposal to conduct a dependent audit with Verify Solutions, an outsourced vendor.

- **Plan Document Review, Edits and Consulting –** Worked with Delta Health and DMC to review and edit several drafts of the restated Medical Plan document.

- **Medical HRA –** Assisted with Medical HRA for retirees. Set up contracts and trusts, coordination with MidAmerica.

- **Total Compensation Statement** – Presented samples and cost to produce statement using an outside vendor.

- **Voluntary Benefits** – Provided overview of voluntary products for union meeting.

2010 Renewal and Marketing – By Line of Coverage

- **Marketing Efforts / Results**

  1. Prescription Drugs – Presented KPPC savings analysis and conducted Rx PBM RFP with three direct PBM vendors and VHA coalition. Savings estimate: $ 100,000
  2. Dental – Worked with Guardian to extend contract & current rates from 8/1/09 to 12/31/09 and establish dental plan contract on a calendar year. Marketed dental plan to 10 dental carriers. Savings estimate: $30,000
  3. Vision – Recommended move to VSP ASAP for employee savings.
  4. Life/AD&D/LTD – Marketed to 7 vendors. Assisted with implementation of CIGNA effective 1/1/10. DMC savings: $75,000
  5. Stop Loss Renewal – Marketed and negotiated Stop Loss agreement. Moved to HCC effective 11/1/09.
  6. EAP Request for Proposal – Conducted a full Request for Proposal to 3 nationwide EAP vendors. Recommended move to a new vendor. Estimated savings: $20,100
  7. TPA – Presented Keenan's TPA abilities.

- **2010/2011 Renewals**
  1. PBM – next renewal 4/1/10
  2. Consulting – next renewal 5/1/10
  3. FSA – next renewal 6/1/10
  4. TPA – next renewal 8/1/10
  5. Stop Loss – next renewal 11/1/10
  6. EAP – next renewal 11/1/10
  7. Dental – next renewal 1/1/11
  8. Life/AD&D – next renewal 1/1/13

HR and Benefits Administration Support

- **Vendor Management** – Set up meeting with all vendors to address expectations and service issues.

- **Client Service Meetings** – Established monthly client service meetings to discuss projects and tasks. Prepared Client Service notes to document due dates, status, next steps and completion of tasks.

- **Employee Communications** – Provided Enrollment Guide design and preparation, Open Enrollment postcards, flyers and posters.

- **Personal Choices** – Established and maintained employee benefit website. Sent out post cards announcing change.

- **Education** – Offered several webinars to DMC (Medicare Demand Letter, COBRA Subsidy, HIPAA Compliance for Employers). Provided periodic

information on legislation or compliance issues, including access to the Keenan NOW and Keenan Briefings.

- **FSA Open Enrollment Assistance –** Vendor coordination/management and review/edits of communications.

- **Annual Benefit Fair –** Assisted with planning and vendor coordination. Participated at fair.

- **Compliance –**
  Medicare Part D – Provided model Certificates of Credible Coverage for Medicare eligible plan members and assisted with online filing at CMS website.

- **Insurance Reference Guide** - Provided 2009 Insurance Reference Guide for Human Resources staff.

- **Service Assistance –** Assisted with administration/service issues, as needed.

DOCTORS
MEDICAL CENTER

MEDCO HEALTH SOLUTIONS: EMPLOYEE PHARMACY BENEFITS

Tab 8

WEST CONTRA COSTA COUNTY HEALTH DISTRICT BOARD
AGENDA ITEM REQUEST / RECOMMENDATION
DOCUMENTATION FORM

TO: **WCCHD Board**

FROM: **Richard S. Reid, CFO**

DATE: **April 28, 2010**

SUBJECT: Approve, based upon JPA recommendation, to hire Medco Health Solutions as prescription Drug Vendor for Employee Drug Insurance

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REQUEST / RECOMMENDATION(S): Based upon recommendation from the JPA, to Approve and authorize the Chief Financial Officer, to execute on behalf of DMC, a three (3) year contract with Medco Health Solutions to provide an integrated prescription drug program for the DMC employees and their applicable dependents. The effective date of the new contract is August 1, 2010.

FISCAL IMPACT: Total projected costs for three (3) years is $3,300,000 or $976,000 for year one (1) and $1,162,000 for years two(2) and three(3). The first year represents an annual saving of $163,000 over the budgeted amount. The savings in 2010 will be $100,000.

STRATEGIC IMPACT: The prescription drug plan provided by Medco will provide the employees with an enhanced drug benefit over the current plan. There is no reduction to the employees. The benefit will be enhanced via increased cost savings to the employee with a more robust mail order program and better care management available through Medco dedicated care teams.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION:

Presentation Attachments: Yes _X_ No ____

Requesting Signature: Richard S Reid Date: 4/22/10

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____
Vote of Board Members:

_____ Unanimous (Absent_____)
Ayes: _____ Noes: _____
Absent: _____ Abstain: _____

I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person: Richard Reid

Attested _____
Eric Zell, District Board Secretary

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

INTEGRATED PRESCRIPTION DRUG PROGRAM AGREEMENT

THIS AGREEMENT is entered into as of the 1st day of August, 2010 (the "Effective Date") between Medco Health Solutions, Inc. ("Medco"), located at 100 Parsons Pond Drive, Franklin Lakes, New Jersey 07417, through Systemed, a Medco business, and Doctors Medical Center ("SPONSOR"), located at SPONSOR ADDRESS.

WHEREAS, SPONSOR is part of the Rx Benefit Solution Coalition (the "Coalition")

WHEREAS, SPONSOR provides for the payment of prescription drugs and related services for persons eligible to receive such benefits through affiliation with a group that has a contract or other arrangement in effect with SPONSOR; and

WHEREAS, Medco, provides prescription drug benefits programs and, in connection therewith, has established networks of participating retail pharmacies and operates a system for the processing, fulfillment and payment of claims for prescription drugs furnished by such pharmacies; and

WHEREAS, Medco's Medco By Mail mail order pharmacy affiliates are licensed pharmacies which provide prescription drugs via a mail order service; and

WHEREAS, SPONSOR desires to retain the services of Medco and its subsidiaries and affiliates, including Medco Health, L.L.C., which holds TPA licenses in certain states, as applicable, to provide a prescription drug benefit program (the "Program") including, but not limited to, retail pharmacy and mail order pharmacy and specialty drug pharmacy services for eligible persons, point-of-care, physician office communications and cost containment initiatives developed and implemented by Medco, which may include communications with prescribers, patients and/or participating pharmacies, and financial incentives to participating pharmacies for their participation in such initiatives (collectively, "PBM Services").

NOW, THEREFORE, in consideration of the premises and the mutual covenants contained herein, the parties hereto agree as follows:

1. DEFINITIONS

1.1. **"AWP"** means the average wholesale price of the Covered Drug, as set forth in the current price list in recognized sources such as First DataBank's National Drug Data File if available, or other nationally recognized source determined by Medco. Under the Retail Pharmacy Program, AWP is based on the package size submitted, and for Compound Prescriptions is 1.25 times the AWP of the submitted Covered Drug. Under the Mail Order Pharmacy Program, AWP is based on package sizes of 100 units for capsules and tablets, 16 oz. quantities for liquids, and the manufacturer's smallest available package size for injectable Covered Drugs (or the next closest package size if such quantities or sizes are not available), and all other Covered Drugs will be priced as individual units or smallest package size available (e.g., per vial, per suppository, etc.). If First DataBank or other applicable source changes the methodology for calculating AWP or ceases publishing or replaces AWP, or Medco utilizes another recognized pricing source or a pricing benchmark other than AWP, in a way that changes the economics of the Program (hereinafter "AWP Change or Replacement", the parties agree to modify the Program Pricing Terms to preserve the parties' relative economics before such changed methodology or other event.

Prior to an AWP Change or Replacement, Medco shall (1) provide SPONSOR with at least 90 days notice of the effective date of the AWP Change or Replacement, but if the effective date of the AWP Change or Replacement is less than 90 days before Medco knows that the AWP Change

or Replacement will definitely occur, then Medco shall provide SPONSOR with as much advance notice as is reasonably practicable under the circumstances; (2) provide SPONSOR with written illustration of the financial impact of the AWP Change or Replacement (e.g., specific drug examples) and a written statement of the expected aggregate annual impact of the AWP Change or Replacement at least 75 days prior to the effective date of the AWP Change or Replacement, but if the effective date of the AWP Change or Replacement is less than 75 days before Medco knows that the AWP Change or Replacement will definitely occur, then Medco shall provide SPONSOR with the written illustration and statement described above as soon as is reasonably practicable under the circumstances.

1.2. **"Brand Name Drugs"** means all single-sourced brand drugs and multisource brand drugs as set forth in First Databank's National Drug Data File or such other nationally recognized source, as reasonably determined by Medco.

1.3. **"Business Days" or "business days"** means all days except Saturdays, Sundays, and federal holidays. All references to "day(s)" are to calendar days unless "business day" is specified.

1.4. **"Compound Prescription"** means a prescription that meets the following criteria: two or more solid, semi-solid or liquid ingredients, at least one of which is a Covered Drug, that are weighed or measured then prepared according to the prescriber's order and the pharmacist's art.

1.5. **"Contract Quarter"** means the full three (3) month period commencing on the Effective Date, and each full consecutive three (3) month period thereafter that this Agreement remains in effect.

1.6. **"Contract Year"** means the full twelve (12) month period commencing on the Effective Date, and each full consecutive twelve (12) month period thereafter that this Agreement remains in effect.

1.7. **"Copayment" and/or "Coinsurance"** means the amount to be paid by an Eligible Person for each prescription or authorized refill as determined in accordance with the Plan Design(s).

1.8. **"Covered Drugs"** means drugs which, under state or federal law, require a prescription, including Compound prescriptions. Excluded from Covered Drugs are (i) cosmetic drugs, (ii) appliances, devices, bandages, heat lamps, braces, splints, and artificial appliances, (iii) health and beauty aids, cosmetics and dietary supplements and (iv) OTC products ("Exclusions"). Additional Covered Drugs and/or Exclusions applicable to any individual Group will be designated by SPONSOR in the applicable Plan Design.

1.9. **"Dispensing Fee"** means the amount payable by SPONSOR pursuant to Sections 1, 2 or 3 of Schedule A or Schedule A-1 of this Agreement for a Participating Pharmacy or Medco to dispense a prescription or authorized refill to an Eligible Person.

1.10. **"Eligible Person"** means each person who, through affiliation with a Group, is eligible for prescription drug benefits pursuant to this Agreement, and such person's qualified dependents.

1.11. **"Generic Drug"** means a multisource generic drug set forth in First Databank's National Drug Data File, or such other nationally recognized source, as reasonably determined by Medco that is available in sufficient supply from multiple FDA approved generic manufacturers of such drug.

1.12. **"Group"** means a group of Eligible Persons that have the same Plan Design as designated by SPONSOR.

1.13. **"Integrated Program"** means a program in which Eligible Persons enrolled in such program may have prescriptions dispensed either (i) by a Participating Pharmacy under the Retail Pharmacy Program or (ii) by Medco under the Mail Order Pharmacy Program. Reference to the Retail Pharmacy Program and/or Mail Order Pharmacy Program herein will include services performed

by Medco for Eligible Persons enrolled in the Integrated Program.

1.14. **"MAC" or the "Maximum Allowable Cost"** consists of a list of off-patent drugs subject to maximum allowable cost payment schedules developed or selected by Medco. The payment schedules specify the maximum unit ingredient cost payable by SPONSOR for drugs on the MAC list. The MAC list and payment schedules are frequently updated.

1.15. **"Mail Order Pharmacy Program"** means the program described in Section 4 in which Eligible Persons may submit a prescription along with the applicable Copayment/Coinsurance to Medco for dispensing via mail order.

1.16. **"Minimum Enrollment"** means an enrollment of not less than 1,200 Primary Eligible Participants under the Program.

1.17. **"Participating Pharmacy"** means a retail pharmacy that has entered into an arrangement with Medco that specifies the terms and conditions of the pharmacy's participation, including the rates that Medco will pay the pharmacy to participate in Medco's retail network(s) servicing SPONSOR's Program including the rates that Medco will pay the pharmacy.

1.18. **"Plan Design"** means Program drug coverage, days supply limitation, Copayment/Coinsurance, Formulary (including Formulary drug selection and relative cost indication) and other Program specifications applicable to the Program designated by SPONSOR as set forth in this Agreement or otherwise documented between the parties.

1.19. **"Primary Eligible Participant"** means each Eligible Person, excluding Eligible Persons who are qualified dependents.

1.20. **"Program Pricing Terms"** means the (i) financial or pricing terms, allowances and guarantees set forth in Schedule A or Schedule A-1, as appropriate of this Agreement, and (ii) performance standards and penalties set forth in Section 5 of this Agreement.

1.21. **"Retail Pharmacy Program"** means the program described in Section 3 in which Eligible Persons may purchase Covered Drugs from a Participating Pharmacy upon verification of Program eligibility and payment of the applicable Copayment/Coinsurance, and the claim is submitted by the Participating Pharmacy to Medco for payment in accordance with this Agreement and the applicable Medco Participating Pharmacy agreement.

1.22. **"Specialty Drugs"** means pharmaceutical products that are generally biotechnological in nature, with many requiring injection or non-oral methods of administration, and that may have special shipping or handling requirements. Some of the disease categories currently in Medco's specialty pharmacy programs include cancer, multiple sclerosis, Hepatitis C, rheumatoid arthritis, cystic fibrosis, infertility, RSV prophylaxis, Gaucher disease, growth hormone deficiency, hemophilia and immune deficiency.

1.23. **"*TelePAID*® System" or "*TelePAID*®"** means Medco's real time, on-line system for adjudicating prescription drug claims submitted by retail pharmacies.

2. SPONSOR FURNISHED INFORMATION

SPONSOR will promptly furnish, in a format acceptable to Medco, all information necessary for Medco to render the services set forth herein. Such information will include, but is not limited to:

2.1. A file of Eligible Persons, and subsequent timely additions and deletions to such file as changes occur. SPONSOR will pay for any Covered Drug dispensed to a person reported by SPONSOR as no longer an Eligible Person, if such notification is not received by Medco at least two (2) full

business days prior to the dispensing date of such prescription.

2.2. Designation, in writing, in Medco's implementation standard benefit add/change form, of those Plan Design features to be determined by SPONSOR.

2.3. The reimbursement terms applicable to direct reimbursement claims submitted by Eligible Persons under the Retail Pharmacy Program.

2.4. The type, number, and description of Medco identification cards ("Identification Cards") required under the Retail Pharmacy Program.

3. RETAIL PHARMACY PROGRAM

The specific features of the Retail Pharmacy Program are as follows:

3.1. **Program Coverage** - The Program coverage (Covered Drugs/Exclusions) and days supply limitation covered under the Retail Pharmacy Program will be as designated by SPONSOR. Up to a thirty (30) day supply of Covered Drugs per prescription or refill may be dispensed under the Retail Pharmacy Program.

3.2. **Participating Pharmacy Networks** - Medco will maintain a Participating Pharmacy Network reasonably necessary to provide services under the Retail Pharmacy Program. With regard to Schedule A, Medco will have the responsibility to contract with Participating Pharmacies. Medco will be responsible for any amounts that it owes to Participating Pharmacies that exceeds the reimbursement it receives from SPONSOR as specified in Section 1 of Schedule A. Medco will retain any reimbursement that it receives from SPONSOR as specified in Section 1 of Schedule A that is in excess of the amounts it is obligated to pay to Participating Pharmacies under the Medco traditional offer. Medco will provide SPONSOR with sixty (60) days prior notice of any pharmacy network disruption that affects more than three (3%) of SPONSOR's population.

3.3. **Identification Cards** - Medco will (i) produce Identification Cards for those Eligible Persons designated by SPONSOR, with an accompanying explanatory brochure, and (ii) make direct reimbursement claim forms available through the www.medco.com internet site for use by Eligible Persons who have not received their Identification Cards, or have had them lost or stolen. Medco will distribute Identification Cards and claim forms to the designated Eligible Persons unless otherwise designated by the SPONSOR. All costs associated with distributing and/or mailing such materials are the responsibility of SPONSOR.

3.4. **Claim Adjudication** - Medco will adjudicate claims for prescription drug benefits in accordance with Medco's *TelePAID* System and the applicable Plan Design. Disapproved claims will be transmitted via *TelePAID* to the submitting pharmacy with a brief explanation of the cause or causes for disapproval. Should SPONSOR determine that a previously disapproved claim should be approved, and so direct Medco, adjudication of the claim will be accomplished promptly by Medco. Medco is obligated to pay Participating Pharmacies for all claims adjudicated through the *TelePAID* System. SPONSOR will pay Medco for these claims pursuant to Schedule A or Schedule A-1, as applicable, Section 1. Medco will promptly refer to SPONSOR all non-routine inquiries by insurance departments, attorneys, claimants, or other persons following the denial of any claims.

3.5. **Administrative Services** – Medco will provide, as applicable, the Base Administrative Services and the Additional Administrative Services set forth in Schedule A or Schedule A-1, as applicable.

3.6. **Pricing** - The Program Pricing Terms applicable to the Retail Pharmacy Program are set forth in Schedule A or Schedule A-1 as applicable, in addition to the performance standards and penalties set forth in Section 5.

3.7. **On-Site Pharmacy** - For claims presented by Members at SPONSOR's on-site pharmacy, Medco will adjudicate on-line, including the full spectrum of plan design, eligibility, and safety edits. SPONSOR's on-site pharmacy will be servicing only Members under the Plan administered by Medco. Claims adjudicated through SPONSOR's on-site pharmacy are excluded from all guarantees, Total Rebates and Guaranteed Rebates under this Agreement, unless the on-site pharmacy is a Participating Pharmacy, with a reimbursement rate that is the same as the majority of the other Participating Pharmacies (with a minimum brand discount of AWP (-) 12.62% and a brand and generic dispensing fee of $1.50) and the claim is not subject to 340b pricing. For purposes of this agreement, the SPONSOR's On-Site Pharmacy is identified as NABP# XXXXXX.

4. MAIL ORDER PHARMACY PROGRAM

4.1. Program Coverage

4.1.1. The Program coverage (Covered Drugs/Exclusions) and days supply limitation under the Mail Order Pharmacy Program will be as designated by SPONSOR in the applicable Plan Design.

4.1.2. Medco's mail order pharmacies will not be required to dispense prescriptions for greater than a ninety (90) day supply of Covered Drugs per prescription or refill, subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances and manufacturer's recommendations. Prescriptions may be refilled providing the prescription so states. Prescriptions will not be filled (i) more than twelve (12) months after issuance, (ii) more than six (6) months after issuance for controlled drug substances, or (iii) if prohibited by applicable law or regulation.

4.2. Dispensing Procedures

4.2.1. Medco's mail order pharmacies will dispense Covered Drugs to Eligible Persons, and dispense generic drugs when authorized, in accordance with (i) applicable law and regulations in the state in which Medco's mail order pharmacy is located, and (ii) the terms of this Agreement and Plan Design(s). Any prescriptions that are not dispensed will be returned to the applicable Eligible Person with an explanation as to why it could not be dispensed in accordance with Medco's standard operating procedures.

4.2.2. All matters pertaining to the dispensing of Covered Drugs or the practice of pharmacy in general are subject to the professional judgment of the dispensing pharmacist.

4.2.3. Any drug which cannot be dispensed in accordance with Medco's mail order pharmacy dispensing protocols, or which requires special record-keeping procedures, may be excluded from coverage by Medco.

4.3. **Claim Adjudication** - Medco will adjudicate and pay approved claims for prescription drug benefits in accordance with Medco's *TelePAID* System and the applicable Plan Design. Should SPONSOR determine that a previously disapproved claim should be approved, and so direct Medco, adjudication of the claim will be accomplished promptly by Medco. SPONSOR will pay Medco for claims adjudicated through the *TelePAID* System, pursuant to Schedule A or Schedule A-1, as applicable, Section 2. Medco will promptly refer to SPONSOR all non-routine inquiries by insurance departments, attorneys, claimants, or other persons following the denial of any claims.

4.4. **Pricing** - The Program Pricing Terms applicable to the Mail Order Pharmacy Program are set forth in Schedule A or Schedule A-1, as applicable, in addition to the performance standards and penalties set forth in Section 5. Medco will have the responsibility to contract with drug

wholesalers and manufacturers regarding Medco's purchase of drugs that are dispensed by it under the Mail Order Pharmacy Program. Medco will be responsible for any amounts that it owes drug wholesalers or manufacturers that exceeds the amounts it charges and receives from SPONSOR or Eligible Persons, as specified in Section 2 of Schedule A or Schedule A-1 as applicable. Medco will retain any payment that it receives from SPONSOR or Eligible Persons as specified in Section 2 of Schedule A or Schedule A-1 as applicable that is in excess of the amounts it is obligated to pay to drug wholesalers or manufacturers for the purchase of such drugs that are dispensed under the Mail Order Pharmacy Program.

5. PERFORMANCE STANDARDS AND PENALTIES

5.1. The following performance standards will apply during the Initial Term of this Agreement:

5.1.1. The *TelePAID* System Availability Rate for each Contract Year will be 99.5% or greater. SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each Contract Year that the *TelePAID* System Availability Rate averages less than 99.5% for a Contract Year. "*TelePAID* System Availability Rate" means the percentage of normal operating hours that the *TelePAID* System is operational, excluding scheduled maintenance time, measured on an annual basis.

5.1.2. The Dispensing Accuracy Rate for each Contract Year will be 99.996% or greater. SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each Contract Year that the Dispensing Accuracy Rate is less than 99.996% for a Contract Year. "Dispensing Accuracy Rate" means (i) the number of all mail order pharmacy prescriptions dispensed by Medco in a Contract Year less the number of those prescriptions dispensed by Medco in such Contract Year which are reported to Medco and verified by Medco as having been dispensed with the incorrect drug or strength, divided by (ii) the number of all mail order pharmacy prescriptions dispensed by Medco in such Contract Year.

5.1.3. Medco will dispense all Non-Protocol Prescriptions received each Contract Year under the Mail Order Pharmacy Program within an average of two (2) business days following receipt. All other Mail Order Pharmacy Program prescriptions received each Contract Year will be dispensed within an average of four (4) business days following receipt by Medco. SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each Contract Year that Medco fails to meet either one of these dispensing time period standards. This Section 5.1.3 is subject to a maximum penalty of ___% of the total amount at risk per Contract Year. "Non-Protocol Prescriptions" means Mail Order Pharmacy Program prescriptions for Covered Drugs received by Medco that are in stock and which do not require physician or patient contact or other non-standard procedures prior to dispensing by Medco.

5.1.4. Prescription Drug Plan reporting package will be made available online to SPONSOR within thirty (30) business days of the end of the billing cycle that includes the last calendar day of the reporting quarter for quarterly reports. SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each report series which is not made available within the applicable time periods, subject to a maximum penalty of ___% of the total amount at risk per Contract Year.

5.1.5. At least 98% of all Maintenance Identification Cards issued by Medco each Contract Year will be mailed within an average of four (4) business days following Medco 's receipt and update of a processable eligibility tape or transmission identifying the applicable Eligible Person(s). SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each Contract Year that this standard is not met measured on a Contract Year basis. "Maintenance Identification Cards" means

new Identification Cards issued to individuals who first become Eligible Persons after the Effective Date (exclusive of new Groups or Group re-enrollments) and replacement Identification Cards for Eligible Persons who have lost or had their Identification Cards stolen.

5.1.6. Processable maintenance eligibility transactions received by Medco via host to host, tape or floppy disc before 12:00 p.m. E.T. on any business day will be processed by Medco within an average of two (2) business days of receipt each Contract Year. SPONSOR may assess a penalty against Medco in the amount of $100 for each processable host to host, tape or floppy disc not processed by Medco within this time period, subject to a maximum penalty of ___% of the total amount at risk per Contract Year.

5.1.7. Medco will respond to at least 95% of written inquiries received each Contract Year from an Eligible Person which requires a response (excluding appeals under Section 14.8) within an average of five (5) business days following receipt. SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each Contract Year that this standard is not met measured on a Contract Year basis.

5.1.8. Medco will make available a toll-free member service telephone line for use by Eligible Persons. The target Average Speed of Answer ("ASA") of the member service telephone line each Contract Year will be thirty (30) seconds or less from the time the Eligible Person selects either the IVRU (Interactive Voice Response Unit) option or Member Service Representative option. This ASA standard excludes calls to the toll-free telephone line separately established for Specialty Drugs. SPONSOR may assess a penalty against Medco for failure to meet this standard in the amount of ___% of the total amount at risk for each Contract Year that this standard is not met measured on a Contract Year basis.

5.1.9. The Telephone Abandonment Rate of the member service telephone line will be 5% or less of all incoming calls received during each Contract Year. This standard excludes calls to the toll-free telephone line separately established for Specialty Drugs. SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each Contract Year that this standard is not met measured on a Contract Year basis. "Telephone Abandonment Rate" means (i) the number of incoming telephone calls received by the customer service telephone line during a Contract Year which are abandoned by the caller after a selection is made either to the IVRU (Interactive Voice Response Unit) system or a Member Services Representative, divided by (ii) the total number of incoming telephone calls received by the customer service telephone line during such Contract Year.

5.1.10. Medco will respond to (process a check or reject notice) at least 97% of direct reimbursement paper claims received at the address designated by Medco for such claims each Contract Year from Eligible Persons within an average of five (5) business days following receipt, and all claims will be responded to within ten (10) business days (response means either a check or reject notice has been mailed). SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each Contract Year that this rate is not met measured on a Contract Year basis. This Section 5.1.10 is subject to a maximum penalty of ___% of the total amount at risk per Contract Year.

5.1.11. The Claims Adjudication Accuracy Rate for each Contract Year will be 98.5% or greater. SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each Contract Year that this standard is not met measured on a Contract Year basis. "Claims Adjudication Accuracy Rate" means (i) the number of retail claims, mail order claims and directly submitted paper claims, adjudicated by Medco in a Contract Year that do not contain a material adjudication error, divided by (ii)

the number of all such claims adjudicated by Medco in such Contract Year.

5.1.12. The Member Satisfaction Rate for each Contract Year will be 90% or greater. A penalty of ___% of the total amount at risk per Contract Year may be assessed against Medco for failure to meet this standard. "Member Satisfaction Rate" means (i) the number of Eligible Persons responding to Medco's annual standard Patient Satisfaction Survey as being satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey; SPONSOR must provide timely approvals and responses, and a minimum of 20% of surveys must be returned for the performance standard in this Section 5.1.12 to be applicable.

5.1.13. The First Call Resolution Rate for each Contract Year will be 93% or greater. This standard excludes calls to the toll-free telephone line separately established for Specialty Drugs. SPONSOR may assess a penalty against Medco in the amount of ___% of the total amount at risk for each Contract Year that this standard is not met, measured on a Contract Year basis. "First Call Resolution Rate" means (i) the total number of telephone calls made by an Eligible Person and resolved by a Medco Member Service Representative on the first call as measured by the Eligible Person not calling back the Medco Member Service Call Center within five (5) days regarding the same inquiry, divided by (ii) the total number of telephone calls made by Eligible Persons and received by Medco's Member Service Call Center.

5.1.14. SPONSOR may assess a penalty in the amount of ___% of the total amount at risk if, three (3) months after the Effective Date, those SPONSOR employees who are members of the SPONSOR Program implementation team do not rate Medco's performance in implementing the Program an average of 3 or better on a scale of 1 to 5 (5 being the best), provided SPONSOR and any applicable third party has fully complied with all SPONSOR implementation requirements established pursuant to this Section 5.1.13.

5.1.15. SPONSOR may assess a penalty in the amount of ___% of the total amount at risk per Contract Year if, after the first Contract Year and each successive Contract Year, those SPONSOR employees who are members of the SPONSOR benefits staff do not rate the Medco account team's performance for such Contract Year an average of 3 or better on a scale of 1 to 5 (5 being the best) based on a range of performance criteria agreed to between SPONSOR and Medco at the beginning of such Contract Year. Additional SPONSOR staff members may be included in the survey at the request of Medco.

5.2. Notwithstanding anything to the contrary, Medco's maximum liability under this Section 5 for any Contract Year will not exceed $20.00 per household during such Contract Year with no more than 20% of the total amount at risk on any one guarantee.

5.3. Medco shall provide SPONSOR with a performance guarantee report within ninety (90) days after the end of each Contract Year. Any applicable payments shall be credited to SPONSOR within thirty (30) days after SPONSOR's receipt of the performance guarantee report.

6. FORMULARY

See Schedule A or Schedule A-1 for Formulary section.

7. BILLING/PAYMENT

7.1. Medco will provide SPONSOR with a bi-weekly consolidated invoice for services provided by Medco under the Program, in accordance with the Program Pricing set forth in Schedule A or Schedule A-1 as applicable. All invoices will be paid in full by SPONSOR within two (2)

business days of receipt by wire transfer, electronic debit, or other method approved by Medco in writing.

7.2. SPONSOR will pay Medco for administrative products and services provided by Medco under the Program in accordance with the Administrative Fee provisions set forth in Schedule A or Schedule A-1 as applicable. Medco will provide SPONSOR with an Administrative Fee invoice in accordance with Medco's four (4) week Administrative Fee cycle. SPONSOR will pay Administrative Fee invoices in full within fifteen (15) days of the invoice date.

7.3. If SPONSOR disputes all or a portion of any invoice, SPONSOR will pay the invoice in full and notify Medco, in writing, of the specific reason and amount of any dispute. Medco and SPONSOR will work together, in good faith, to resolve any dispute as soon as reasonably practicable, and Medco will promptly refund to SPNSOR the amount, if any, as the parties agree based on the resolution.

7.4. Subject to review of audited financial statements and/or whether payments due to Participating Pharmacies for Covered Drugs under this Agreement become subject to prompt payment related legislation or regulation, SPONSOR may be required to pay a deposit in an amount equal to one months average claims billing amount or projected amount, which amount may be periodically modified by Medco based on SPONSOR's actual claims experience and enrollment. This deposit may be used by Medco to offset the failure by SPONSOR, for any reason, to make any payments pursuant to the terms of this Agreement and/or to make payments due in accordance with prompt payment legislation or regulation prior to Medco's billing and receipt of SPONSOR's payment due under Section 7.1, and does not, in any way, limit other remedies available to Medco. The deposit, to the extent not utilized to offset any payment default by SPONSOR under this Agreement, will be returned, without interest, to SPONSOR within the greater of one hundred eighty (180) days following termination of this Agreement or following any agreed upon date for extended services.

7.5. Failure by SPONSOR to make any payments in accordance with the terms of this Agreement will constitute a payment default. Notwithstanding Section 10.2 of this Agreement, if SPONSOR fails to cure any such payment default within two (2) days, in addition to other available remedies, Medco may cease performing any or all of its obligations under, or may terminate this Agreement upon five (5) days notice to SPONSOR. After the two (2) day grace period, there will be a late payment fee of 1% per month on the balance due, accruing as of the due date. SPONSOR will reimburse Medco for all collection costs incurred by Medco as a result of any payment default by SPONSOR under this Agreement.

8. RECORDS

8.1. Medco will maintain all claims records relating to services performed under this Agreement as required by applicable law. Such claims records will be in their original form, on microfilm, microfiche or other form determined by Medco. The COALITION's collective claims records may be audited, based on statistical sampling, or on an annual basis, up to three individual COALITION companies may perform individual claims audits, either directly or by a representative reasonably acceptable to Medco, for a maximum period of twenty-four (24) months prior to the agreed upon audit date at no cost. SPONSOR may conduct an audit once annually from January through September on an agreed upon date. Subject to Section 9.3, Medco may retain copies of such claims records for its own use.

8.2. Any audit of Medco's agreements with pharmaceutical manufacturers may be conducted by a top 100 public accounting firm approved by Medco whose audit department is a separate stand alone function of its business and that carries insurance for professional malpractice of at least $2,000,000. The audit will include only those portions of the pharmaceutical manufacturer agreements as necessary to determine Medco's compliance with Section 6 above in respect to

Total Rebates. The COALITION will be entitled to one collective audit, based on statistical sampling, under this Section 6 on behalf of all COALITION members, or up to three individual COALITION members may perform individual manufacturer agreement audits. The audit may be conducted once annually from January through September, at Medco's offices as scheduled by agreement of the parties, but not sooner than ninety (90) days after execution of a confidentiality agreement.

8.3. Any auditor performing an audit under this Section 8 will warrant and represent that it is not providing Litigation Services to any person or entity in connection with any lawsuit, investigation, or other proceeding that is pending or contemplated against Medco. "Litigation Services" include (a) examining pharmacy claims or any other documents or information, or (b) providing advice, analysis, and/or opinions as a disclosed or undisclosed expert or consultant. The auditor must agree that, for a period of one (1) year after completion of the audit, it will not provide Litigation Services in any lawsuit, investigation, or other proceeding brought against Medco, except for Litigation Services to SPONSOR in any proceeding against Medco.

8.4. Upon request, SPONSOR will furnish its most recent audited financial statement to Medco.

9. CONFIDENTIAL INFORMATION

9.1. The Confidential Information of a party (the "disclosing party") which is disclosed to the other party (the "receiving party") will be held by the receiving party in strictest confidence at all times and will not be used by the receiving party (or its affiliates, employees, officers, directors or limited liability company managers ("Representatives")) for any purpose not previously authorized by the disclosing party, except as necessary for Medco to perform the services under this Agreement. The Confidential Information of the disclosing party will not be disclosed or divulged by the receiving party to anyone, except with the prior written permission of the disclosing party and on the condition that the party to whom the Confidential Information is disclosed agrees in writing in advance to be bound by these terms and conditions. The receiving party may disclose the Confidential Information to those of its Representatives who need to review the Confidential Information for the purposes authorized by the disclosing party but only after the receiving party has informed them of the confidential nature of the Confidential Information and directs them to treat the Confidential Information in accordance with the terms of this Agreement. The disclosing party retains all right, title and interest in and to its Confidential Information.

The term "Confidential Information " includes, but is not limited to, any information of either the receiving or disclosing party (whether oral, written, visual or fixed in any tangible medium of expression), relating to either party's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers, contractors, cost and pricing data, trade secrets, know-how, processes, plans, reports, designs and any other information of or relating to either party's business, including its therapeutic and disease management programs, but does not include information which (a) was known to the receiving party before it was disclosed to the receiving party by the disclosing party, (b) was or becomes available to the receiving party from a source other than the disclosing party, provided such fact is evidenced in writing and the source is not bound by a confidentiality obligation to the disclosing party, or (c) is developed by the receiving party independently of the disclosing party's Confidential Information, provided that such fact can be documented. Each party will also keep the terms of this Agreement confidential as Confidential Information, except as required by law or regulation.

If the receiving party is requested or required (by oral questions, interrogatories, requests for information or documents, subpoena, civil investigative demand, any informal or formal investigation by any government or governmental agency or authority, law or regulation, or otherwise) to disclose any of the Confidential Information, the receiving party will notify the disclosing party promptly in writing so that the disclosing party may seek a protective order or

other appropriate remedy or, in its sole discretion, waive compliance with the terms of this Agreement. The receiving party agrees not to oppose any action by the disclosing party to obtain a protective order or other appropriate remedy. If no such protective order or other remedy is obtained, or the disclosing party waives compliance with the terms of this Agreement, the receiving party will furnish only that portion of the Confidential Information which it is advised by counsel is legally required and will exercise its reasonable best efforts to obtain reliable assurance that confidential treatment will be accorded the Confidential Information.

9.2. SPONSOR and Medco may not utilize the service marks, trademarks, or tradenames of any other party to this Agreement, or any service marks, trademarks, or tradenames so similar as likely to cause confusion, without express written approval of such other party. The programs implemented by Medco will remain the sole property of Medco and will only be used by SPONSOR in connection with the Program and so long as Medco administers the Program.

9.3. Medco and SPONSOR will comply with all applicable laws and regulations regarding patient confidentiality as provided in the Business Associate Agreement between the parties. Medco will not furnish any SPONSOR identifiable data or information to any third party without the written consent of SPONSOR, except as reasonably necessary to implement and operate the Program and fulfill its obligations pursuant to this Agreement or as required by applicable law. The restrictions set forth in this Section 9 will not apply to claims data or information which is not identifiable on a SPONSOR basis.

10. TERM OF AGREEMENT

10.1. This Agreement will remain in effect for an initial term of three (3) years from the Effective Date (the "Initial Term"). Notwithstanding the issuance of a termination notice, Medco agrees to continue to render services hereunder and SPONSOR agrees to pay for services of Medco in accordance with the terms of this Agreement for any claims incurred for prescription drug benefits by Eligible Persons while this Agreement was in force.

10.2. In the event of a material breach of this Agreement, the party alleging such breach will give written notice thereof to the other parties. If such breach is not cured within sixty (60) days of receipt of such notice, the non-breaching party may terminate this Agreement upon written notice to the other party.

10.3. In the event of termination of this Agreement Medco shall cooperate with SPONSOR to permit a prompt transition to a replacement pharmacy benefits manager ("Replacement PBM"). Medco agrees to provide data Medco has in its possession (excluding any Medco confidential or proprietary data) to the Replacement PBM as may be reasonably required by the Replacement PBM to perform PBM functions for SPONSOR. Medco shall have no obligation to meet data requirements requested by the SPONSOR or the Replacement PBM which are not consistent with Medco's reasonable standard data formats.

11. FORCE MAJEURE

Neither Medco nor SPONSOR will be deemed to have breached this Agreement or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Agreement if prevented from doing so by a cause or causes beyond its control. Without limiting the generality of the foregoing, such causes include acts of God or the public enemy, fires, floods, storms, earthquakes, riots, acts of terrorism, acts of war, war-operations, restraints of government, power or communications line failure or other circumstances beyond such party's control, or by reason of the judgment, ruling or order of any court or agency of competent jurisdiction, or change of law or regulation (or change in the interpretation thereof) subsequent to the execution of this Agreement.

12. INDEMNIFICATION/LIMITATION OF LIABILITY

12.1. Medco will indemnify and hold SPONSOR, its subsidiaries, affiliates, and their officers, directors and employees (each a "SPONSOR Indemnified Party") harmless from and against claims, suits, actions, or causes of action ("Actions") asserted against a SPONSOR Indemnified Party arising from services rendered by Medco pursuant to this Agreement to the extent the Action arises from Medco's negligence or willful misconduct, or breach of this Agreement, provided that (a) SPONSOR has given reasonable notice to Medco of the Action, and (b) no SPONSOR Indemnified Party has, by act or failure to act, compromised Medco's position with respect to the resolution or defense of the Action.

12.2. SPONSOR will indemnify and hold Medco, its subsidiaries and affiliates, and their respective officers, directors and employees (each a " Medco Indemnified Party") harmless from and against Actions asserted against a Medco Indemnified Party arising from (i) breach of this Agreement by SPONSOR, (ii) negligence or willful misconduct of SPONSOR, or (iii) the provision of patient identifiable or Program information or data by a Medco Indemnified Party to SPONSOR or SPONSOR's designees, or the subsequent use or disclosure of such information or data by SPONSOR or its designees, provided that (a) the Medco Indemnified Party has given reasonable notice to SPONSOR of the Action, and (b) no Medco Indemnified Party has, by act or failure to act, compromised SPONSOR's position with respect to the resolution or defense of the Action.

12.3. Medco will maintain, during the term of this Agreement, liability coverage with limits not less than $5,000,000 per occurrence and in the aggregate per policy year, with excess liability coverage in an amount not less than $10,000,000 per policy year. Evidence thereof will be furnished to SPONSOR upon request.

12.4. Except as provided in Section 12.1 above, neither Medco nor any subsidiary, affiliate, or any of their respective directors, officers or employees, will be responsible for any Action resulting from the provision of or failure to provide pharmaceutical goods or services or any other action or failure to act by any retail pharmacy, pharmaceutical manufacturer or other pharmaceutical providers in connection with this Agreement.

12.5. The liability of Medco to SPONSOR for any negligent or willful misconduct by Medco will be limited to the per occurrence liability insurance amount set forth in this Section 12.3.

12.6. Medco or SPONSOR will not be liable to each other for incidental, consequential, punitive, special, or exemplary damages.

13. EXCLUSIVITY

Medco will be the exclusive provider and administrator of PBM Services to SPONSOR and its subsidiaries while this Agreement is in effect. Nothing contained herein, however, will prohibit Medco or any affiliated entity from providing or administering PBM Services and related programs and services to any other entity while this Agreement is in effect.

14. GENERAL

14.1. **Independent Contractor** - The relationship between Medco and SPONSOR will solely be that of independent contractors engaged in the operation of their own respective businesses.

14.2. **Assignment** - This Agreement may not be assigned by any party without the written approval of the other parties provided, however, that services to be performed by Medco hereunder may be performed by its subsidiaries, affiliates, divisions and/or designees. The duties and obligations of the parties will be binding upon, and inure to the benefit of, successors, assigns, or merged or consolidated entities of the parties.

14.3. **No Third-Party Beneficiary** - This Agreement has been entered into solely for the benefit of SPONSOR and Medco, and is not intended to create any legal, equitable or beneficial interest in any third party or to vest in any third party any interest as to enforcement or performance.

14.4. **Notices** - All notices required under this Agreement will be in writing and sent by certified mail, return receipt requested, hand delivery or overnight delivery by a nationally recognized service addressed as follows:

If to SPONSOR:
NAME
ADDRESS
CITY/STATE
Attention:

If to Medco:
Medco Health Solutions, Inc.
100 Parsons Pond Drive
Franklin Lakes, NJ 07417
Attention: Anthony Palmisano Jr.
Vice President and Assistant General Counsel
Customer and Commercial Contracting

14.5. **Amendments** - This Agreement may be amended only in writing when signed by a duly authorized representative of each party.

14.6. **Financial Responsibility** - If Medco has reasonable grounds to believe that SPONSOR may not meet its payment obligations under this Agreement as they become due, Medco may request information and/or reasonable assurances (including a deposit) from SPONSOR as to its financial responsibility. If the information or assurances are not furnished to Medco within five (5) days, or are not satisfactory in Medco's reasonable judgment, Medco may, upon written notice, immediately terminate this Agreement or suspend performance pending receipt of the requested information or assurances.

14.7. **Plan Design** - The Program Pricing Terms set forth in this Agreement are based upon the Plan Designs, Minimum Enrollment and Program specifications agreed to between the parties as reflected in this Agreement and as otherwise hereafter agreed to by the parties in writing. The Program Pricing Terms are also based upon SPONSOR funding 50% or greater of the costs of Covered Drugs for its Eligible Persons. Any modification of the Plan Design or Program specifications, failure to maintain Minimum Enrollment, or inclusion of Eligible Persons or Groups with Covered Drugs funded less than 50% by SPONSOR, may result in a retroactive modification by Medco of the Program Pricing Terms. SPONSOR will provide Eligible Persons with at least thirty (30) days' prior notice of approved Plan Design changes. If the number of SPONSOR's Eligible Persons eligible for Medicare is materially reduced or eliminated for any reason, Medco may communicate with those persons at Medco's expense regarding Part D options, including Medco Part D services, and the Program Pricing Terms may be modified to reflect the reduction or elimination.

14.8. **ERISA Claims and Appeals**

SPONSOR will not name or represent that Medco is, and Medco will not be, a Plan Administrator or, except as specifically set forth in this section, a fiduciary of any prescription drug benefit plan (the "Plan"), as those terms are used in the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 et seq., and the regulations promulgated under ERISA. SPONSOR will have complete discretionary, binding, and final authority to construe the terms of the Plan, to interpret ambiguous Plan language, to make factual determinations regarding the payment of claims or provisions of benefits, to review denied claims and to resolve complaints by Eligible Persons.

SPONSOR delegates to Medco the limited authority and discretion solely to undertake administrative and/or clinical initial determinations, first-level, second-level and urgent appeals of

claims eligibility and benefit applications determinations filed by Eligible Persons with SPONSOR's Program. Medco will process and determine all filed administrative and/or clinical first-level, second-level and urgent appeals under the procedures and within the time frames specified in the Department of Labor claims processing regulations, 29 C.F.R. § 2560.503-1 (the "Claims Procedure Regulations"). For this purpose, Medco agrees that it shall be the appropriate named fiduciary in accordance with Section 2560.501-1 (h) of the Claims Procedure Regulations. Medco's decisions will be conclusive and binding and not subject to further review by SPONSOR.. If, however, with respect to a claim or appeal, any of the duties, whether delegated to Medco or not, are assumed or acted upon by SPONSOR, or by any agent or vendor of such entity (e.g. utilization management vendor), then Medco will not have any fiduciary duties or discretionary authority with respect to such claim or appeal, and SPONSOR will be deemed to have such fiduciary duties and discretionary authority and will be solely liable for such claim or appeal. Notwithstanding the services of Medco under this section, all decisions concerning the rendering of health care services are determined by the Eligible Person's physician, hospital or other health care provider and the Eligible Person.

14.9. **Taxes and TPA** - Any applicable sales, use, or other similarly assessed and administered tax imposed on items dispensed, or services provided hereunder, or any other amounts Medco may incur or be required to pay arising from our relating to Medco's performance of services as a third-party administrator in any jurisdiction, will be the sole responsibility of SPONSOR. If Medco is legally obligated to collect and remit sales, use, or other similarly assessed and administered tax in a particular jurisdiction, or to incur or pay any amount relating to third-party administrator services, the tax or other amount will be reflected on the applicable invoice or subsequently invoiced at such time as Medco becomes aware of such obligation or as such obligation becomes due.

14.10. **Governing Law** - This Agreement will be construed and governed in accordance with the laws of the State of New Jersey. However, all matters relating to the Mail Order Pharmacy Program operations of Medco will be governed by the laws of the state in which Medco's mail order pharmacy is located.

14.11. **Enforceability** - The invalidity or unenforceability of any of the terms or provisions hereof will not affect the validity or enforceability of any other term or provision.

14.12. **Section Headings** - Section headings are inserted for convenience only and will not be used in any way to construe the terms of this Agreement.

14.13. **Waiver** - The waiver of any breach or violation of any term or provision hereof will not constitute a waiver of any subsequent breach or violation of the same or any other term or provision. No waiver or relinquishment by a party of any right or remedy under this Agreement will occur unless the waiver or relinquishment is in a written document signed by an officer of the party.

14.14. **Approvals** - Whenever approval of any party is required under this Agreement, such approval will not be unreasonably withheld.

14.15. **Organization** - Each party is duly organized, validly existing and in good standing, and has the power to own its property and to carry on its business as now being conducted by it.

14.16. **Authorization** - The execution and delivery of this Agreement and the consummation of the transactions contemplated herein on its part, has been duly authorized by all necessary action by each party.

14.17. **No Conflict of Interest or Other Restrictions** - No party has a conflict of interest which would impact its ability to perform fairly its obligations under this Agreement, and no party is subject to any restrictions, contractual or otherwise, which prevent or would prevent it from entering into this Agreement or carrying out its obligations hereunder.

14.18. **No Violation** - Neither the execution and delivery of this Agreement nor the consummation of the transactions contemplated hereby will be a violation or default of any term or provision of the party's governance documents (e.g., its certificate of incorporation or bylaws or operating agreement) or of any material contract, commitment, indenture, or other agreement or restriction to which it is a party or by which it is bound.

14.19. **Binding Effect** - This Agreement has been duly executed and delivered by each party, and is a valid and binding obligation of each party, enforceable against such party in accordance with its terms, except to the extent that the enforceability thereof may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting creditors' rights generally and general principles of equity.

14.20. **Original Agreement/Counterparts** - The parties will execute two identical originals of this Agreement. Each party will retain one of the originals. This Agreement may be executed in one or more counterparts, any one of which need not contain the signatures of more than one party, but all counterparts taken together will constitute one instrument.

14.21. **Public Announcement** - Except as required by law or regulation, neither party will make any public announcement nor issue any press release relating to this Agreement without the written consent of the other party. This provision does not restrict either party from submitting necessary or appropriate filings with the SEC.

14.22. **Dispute Resolution** - Except for those matters subject to emergent or injunctive relief, in the event that any dispute relating to this Agreement arises between SPONSOR and Medco, either party may, by written notice, demand a meeting regarding the dispute, to be attended by executive officers of each party, who will attempt in good faith to resolve the dispute. If the dispute cannot be resolved through executive negotiations within thirty (30) business days after the date of the initial notice, each party will retain all rights to bring an action regarding such matter in accordance with law.

14.23. **Construction** - SPONSOR and Medco have participated jointly in the negotiation of this Agreement and each has had the advice of legal counsel to review, comment upon and draft this Agreement. Accordingly, it is agreed that no rule of construction shall apply against any party or in favor of any party, and any uncertainty or ambiguity shall not be interpreted against any one party and in favor of the other.

14.24. **Entire Agreement** - This Agreement, together with the Schedules hereto, embodies the entire understanding of the parties in relation to the subject matter hereof, supersedes any prior agreement among the parties in relation to the subject matter hereof, and no other agreement, understanding, or representation, verbal or otherwise, relative to the subject matter hereof exists among the parties at the time of execution of this Agreement.

14.25. **Compliance with Law** – Medco and SPONSOR shall take all actions necessary and appropriate to assure that they comply with all applicable federal, state, and local laws and regulations, including, without limitation, the Anti-Kickback Statute, the Public Contracts Anti-Kickback Act, the Stark Law, and laws and regulations relating to disclosure or notification of plan benefits or the terms of rebate administration under this Agreement to SPONSOR's Groups. Medco's Code of Conduct and its policies and procedures relating to compliance with the above-named laws are available at www.medco.com.

14.26. **Survival** - The provisions of Sections 7.5, 9, 12, and the last sentence of 10.1 will survive the termination of this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement on the date indicated below.

MEDCO HEALTH SOLUTIONS, INC.

BY:_____
(signature)

NAME: Anthony Palmisano Jr.

TITLE: Vice President and Assistant General Counsel
Customer and Commercial Contracting

DATE:_____

DOCTORS MEDICAL CENTER

BY:_____
(signature)

NAME:_____
(type or print name)

TITLE:_____

DATE:_____

214122.2 (4/7/10)efs
(Original 50180.9 -3/20/08)

SCHEDULE A (Traditional)
PROGRAM PRICING TERMS

SPONSOR will pay Medco for services provided under the Program as follows:

1. RETAIL PHARMACY PROGRAM CLAIMS

SPONSOR will pay Medco for Covered Drugs dispensed and submitted by Participating Pharmacies under the Retail Pharmacy Program in an amount equal to the lowest of (i) the pharmacy's usual and customary price, as submitted ("U&C") plus applicable taxes, (ii) the maximum allowable cost ("MAC"), where applicable, plus the Dispensing Fee, or (iii) (A) AWP minus (-) 13.66% and $1.45 Dispensing Fee plus applicable taxes. The guaranteed average annual AWP discount for Brand Drugs will be as set forth below and the guaranteed average annual AWP discount for Generic Drugs will be as set forth below for each Contract Year during the Initial Term[1]. The guaranteed Dispensing Fee per prescription or authorized refill will be as set forth below. Medco will prepare a true up within one hundred eighty (180) days following the end of such Contract Year. Any net shortfall (i.e. shortfalls offset by surpluses across the Brand and Generic discounts) in the aggregate guaranteed discount savings will be matched dollar for dollar by Medco. Any net shortfall in the guaranteed dispensing fees will be measured separately and matched dollar for dollar by Medco. In the event of an increase or decrease in the total number of Participating Pharmacies by greater than five (5) percent, or a change in ownership of five (5) percent or more of Participating Pharmacies in the Broad National Network, Medco may modify the guarantee for Ingredient Costs and Dispensing Fees on an equitable basis. Payment by SPONSOR is subject to the applicable Copayment/Coinsurance amount set forth below.

	30-day network	
Brand Drugs	AWP minus (-) 13.87%	
Generic Drugs	1st Contract Year: AWP minus (-) 66.0% 2nd Contract Year: AWP minus (-) 68.0% 3rd Contract Year: AWP minus (-) 68.0%**	
Dispensing Fee	$1.35 per prescription	

** Only applies if aggregate households in the Coalition is equal to or greater than 30,000.

1.1

The guaranteed average annual AWP discount for Brand Drugs will not include the incremental values from any of the following:

- Claims that adjudicate at the pharmacy's usual and customary price.
- Average AWP or any modification or trending of AWP.
- AWP of any date other than the date the drug is adjudicated.
- The value of any audit recoveries.
- Any savings generated from clinical programs.
- Compound drugs.
- Specialty drugs.
- Single-source Generic drugs excluded from the Generic Drug discount guarantee.
- Any member copayment, cost share or coinsurance.

[1] The guarantee will exclude all Single-source Generic drugs that are within the 180-day exclusivity period as granted by the FDA.

1.2 **Generic Discount Guarantee** - The Guaranteed Effective Generic Discount Rate is the discount off AWP, in aggregate, overall Retail generic claims including MAC, non-MAC, ZBD and U&C claims. The guarantee will be calculated using the following formula: [(Total Retail Generic AWP – Discounted Retail Generic AWP) / (Total Retail Generic AWP)]. The AWP is based on the NDC11 of the drug dispensed on the day the drug is dispensed. A ZBD claim is one in which a member pays the full cost of the prescription at the point of sale. The guaranteed average annual AWP discount for Generic Drugs will exclude all Single-source Generic Drugs that are within the one hundred eighty (180) day exclusivity period as granted by the FDA and will not include the incremental values from any of the following:

- Average AWP or any modification or trending of AWP.
- AWP of any date other than the date the drug is adjudicated.
- The value of any audit recoveries.
- Any savings generated from clinical programs.
- Compound drugs.
- Specialty drugs.
- Any member copayment, cost share or coinsurance.

1.3 **Dispensing Fee Guarantee** - The maximum average dispensing fee per retail brand and generic claim is calculated in aggregate using the following formula: [(Total Retail Brand Dispensing Fee) / (Total Number of Retail Brand Claims)].

1.4 **Copayment/Coinsurance** - The Copayment/Coinsurance amount for each prescription or refill dispensed by a Participating Pharmacy under the Retail Pharmacy Program will be as designated for each Group in the applicable Plan Design(s). For Covered Drugs there will be a charge equal to the lower of (a) the U&C (b) the applicable Copayment or (c) the Discounted AWP and Dispensing Fee plus applicable taxes.

1.5 **Direct Claims** - The reimbursement terms applicable to direct reimbursement claims submitted by Eligible Persons under the Retail Pharmacy Program will be the same as the terms set forth in this Section 1, unless otherwise provided in writing by SPONSOR to Medco.

2. MAIL ORDER PHARMACY PROGRAM CLAIMS

SPONSOR will pay Medco for Covered Drugs dispensed by a Medco mail order pharmacy under the Mail Order Pharmacy Program in an amount equal to an Ingredient Cost plus Dispensing Fee for each Covered Drug dispensed, less the applicable Copayment/Coinsurance amount, as such terms are defined below:

2.1. **Ingredient Cost** - The Ingredient Cost will be calculated at the lower of MAC or Discounted AWP with guarantees as set forth below:

Brand Drugs	AWP – 21.98%
Generic Drugs[2]	1st Contract Year: AWP minus (-) 70.0% 2nd Contract Year: AWP minus (-) 72.0% 3rd Contract Year: AWP minus (-) 72.0%**

** Only applies if aggregate households in the Coalition is equal to or greater than 30,000.

Medco will prepare a true up one hundred eighty (180) days following the end of such Contract Year. Any net shortfall (i.e. shortfalls offset by surpluses across the three components) in the aggregate guaranteed savings will be matched dollar for dollar by Medco.

2.1.1. The Mail Brand Discount is the discount applied to the AWP of each mail order brand

[2] The guarantee will exclude all Single-source Generic drugs that are within the 180-day exclusivity period as granted by the FDA.

drug at the point of sale. The AWP is based on the package size of 100 units or 16-ounce quantities, or the next larger quantity if such specific quantities are not available. The guaranteed AWP discount for Brand Drugs will not include the incremental values from any of the following:

- Average AWP or any modification or trending of AWP.
- AWP of any date other than the date the drug is adjudicated.
- The value of any audit recoveries.
- Any savings generated from clinical programs.
- Compound drugs.
- Specialty drugs.
- Single-source Generic drugs excluded from the Generic Drug discount guarantee.
- Any member copayment, cost share or coinsurance.

2.1.2. The Guaranteed Mail Generic Discount Rate is the effective discount off AWP, in aggregate, over all Mail generic claims including MAC, non-MAC and ZBD claims. The guarantee will be calculated using the following formula: [(Total Mail Generic AWP – Discounted Mail Generic AWP) / (Total Mail Generic AWP)]. The AWP is based on the package size of 100 units or 16-ounce quantities, or the next larger quantity if such specific quantities are not available. A ZBD claim is on in which a member pays the full cost of the prescription at the point of sale. The guaranteed average annual AWP discount for Generic Drugs will exclude all Single-source Generic Drugs that are within the one hundred eighty (180) day exclusivity period as granted by the FDA and will not include the incremental values from any of the following:

- Average AWP or any modification or trending of AWP.
- AWP of any date other than the date the drug is adjudicated.
- The value of any audit recoveries.
- Any savings generated from clinical programs.
- Compound drugs.
- Specialty drugs.
- Any member copayment, cost share or coinsurance.

2.2. **Dispensing Fee** - The Dispensing Fee per prescription or authorized refill is $0.00. Dispensing Fees are inclusive of postage. If postage rates (i.e., U.S. mail and/or applicable commercial courier services) increase during the term of this Agreement, the pricing will be increased to reflect such increase(s).

2.3. **Copayment/Coinsurance** - The Copayment/Coinsurance amount for each prescription or refill dispensed by a Medco mail order pharmacy under the Mail Order Pharmacy Program shall be as designated for each Group in the applicable Plan Design(s). If the amount of the applicable Copayment/Coinsurance paid by an Eligible Person for a prescription or refill dispensed by Medco exceeds the Ingredient Cost (as defined in 2.1 above) plus Dispensing Fee (as defined in Section 2.2 above) plus any applicable taxes, then Medco shall return to the Eligible Person an amount equal to the Copayment/Coinsurance amount, less the sum of the applicable Ingredient Cost plus Dispensing Fee plus any applicable taxes, for the prescription or refill. Eligible Persons must pay the applicable Copayment or Coinsurance amount to Medco for each prescription or authorized refill under the Mail Order Pharmacy Program. Medco may suspend Mail Order Pharmacy Program services to an Eligible Person who is in default of any Copayment or Coinsurance amount due Medco. SPONSOR will be responsible for any unpaid Eligible Person Copayment or Coinsurance amounts, in accordance with Medco's standard credit policy, if payment has not been received from the Eligible Person within one hundred twenty (120) days of dispensing. SPONSOR will be billed following the one hundred twenty (120) day collection period, with payment due in accordance with the payment terms set forth in Section 7.2 of this Agreement.

3. SPECIALTY DRUG CLAIMS

Notwithstanding anything to the contrary in Section 2 above and elsewhere in the Agreement, SPONSOR will pay Medco for Covered Drugs designated as Specialty Drugs under the Mail Order Pharmacy Program on a separate ingredient cost basis plus applicable Dispensing Fee, subject to the Copayment/Coinsurance in the applicable Plan Design. Under the Retail Pharmacy Program, SPONSOR will pay Medco for Specialty Drugs according to the pricing set forth in Section 1 of Schedule A. A Specialty Drug of limited or exclusive distribution through specific retail pharmacies ("Limited Distribution Specialty Drug") is not subject to terms of Schedule A, Section 1. SPONSOR shall pay Medco for Limited Distribution Specialty Drugs in the same amount that Medco reimburses the retail pharmacy for such drug, including Ingredient Cost and Dispensing Fee. Medco will be the exclusive administrator of Specialty Drugs to SPONSOR while this Agreement is in effect. Specialty Drugs may be provided by Medco or other third-party specialty pharmacy that has a written arrangement with Medco. Medco may add or delete products, or modify pricing terms during the term of this Agreement. Specialty Drugs are excluded from calculations, guarantees, credits and payments regarding Total Rebates under the Mail Order Pharmacy Program and the Retail Pharmacy Program set forth in this Agreement. The terms and pricing set forth in this section apply only to SPONSOR's pharmacy benefit and not to SPONSOR's medical benefit. Medco will provide a current list of Specialty Drugs and associated prices upon SPONSOR's written request.

4. ADMINISTRATIVE FEES

4.1. SPONSOR will pay to Medco a Base Administrative Fee in the amount of $0.00 per paid claim processed by Medco under the Retail Pharmacy Program/Mail Order Pharmacy Program and Specialty Pharmacy Program for the following Base Administrative Services, as applicable:

- Administration of eligibility submitted via tape or telecommunication in a Medco standard format
- Eligibility maintenance (minimum of weekly updates)
- Dependent Eligibility Certification System (DECS)
- Medco's client support system (e-SD) for on-line access to current eligibility (equipment, installation and line charges are responsibility of SPONSOR)
- Administration of SPONSOR's Plan Design in Medco format
- In-network claims adjudication via *TelePAID* on-line claims adjudication system
- Coordination of Benefits Level I (when flagged on eligibility records)
- Twelve (12) months on-line claims history retention (for use in claims processing)
- Processing associated with Medco by Mail Pharmacy Program prescriptions
- Designated Systemed Account Team
- Client clinical and plan consulting, analysis and cost projections
- Annual analysis of program utilization and impact of plan design and managed care interventions
- Processing of prescriptions received via Internet, fax, phone or mail
- Refill orders received by phone or Internet 24 hours a day, 7 days a week
- Handling and postage expense of mail-order prescriptions
- Braille prescription labels for visually impaired
- Communication/educational materials included in medication packages
- General communications regarding utilization of mail-order
- Medco Welcome Package and ID Cards for new members (two per family)
- Medco standard member communications
- Standard member web site capabilities including:
  - online prescription ordering and status
  - prescription pricing information
  - coverage and benefit plan information
- health news information
- Explanation of Benefits (EOB) for out-of-network claims

- Direct reimbursement claim form (also available via www.medcohealth.com)
- Coordination of benefits (COB) claim form
- Benefit denial letters for instances where Eligible Person/drug are not covered
- TDD-TTY services for hearing impaired to access Customer Service Department
- Integrated Concurrent Drug Utilization Review (DUR) via *TelePAID*
- Physician Profiling Program
- Prescription Drug Plan Report Package
- Semi-Annual Performance Summaries
- Establish, maintain, credential, and contract an adequate panel of Participating Pharmacies
- Development and distribution of communication materials to Participating Pharmacies regarding the Program
- Toll-free access to Help Desk for eligibility/claims processing assistance
- Toll-free access to Participating Pharmacies for DUR assistance
- Monitor Participating Pharmacy compliance, including submission of U&C, generic dispensing rates, formulary program conformance, DUR intervention conformance, patient utilization, and drug mix and managed through the Coordinated Rx[SM] Program
- Toll-free telephone access to voice response unit for location of Participating Pharmacies in zip code area
- Medco Pharmacy Audit Program[3]
- Toll-free telephone access to Customer Service for the program for use by Eligible Persons, SPONSOR benefits personnel and physicians
- Gatekeeper program – Medco's assistance program for older adults
- 24-hour access to a Medco pharmacist via toll-free telephone service

4.2. SPONSOR will pay to Medco a Base Administrative Fee in the amount of $1.17 per paid claim processed at the SPONSOR's On-site pharmacy, if applicable.

4.3. SPONSOR will also pay for Additional Administrative Services requested by SPONSOR and provided by Medco under the Program as follows:

• Extra Identification Cards	$0.35 per card
• Direct reimbursement/out-of-network claims adjudication (including check and EOB to Eligible Person)	$1.75 per claim
• Hard copy eligibility submission	Data entry charges
• Mailings direct to Eligible Persons or SPONSOR location	Postage charges
• Medco's Coverage Management Program, consisting of: prior authorization, step therapy, quantity duration/ dose duration, quantity per dispensing event capabilities, and dose optimization (coverage option) and includes initial determinations and first level of appeals	$48.00 per case[4]
• Reviews and Appeals Management	
– Includes all initial determinations and first level appeals and, if selected by SPONSOR, all second level and urgent appeals	$55.00 per case[5]
• Second level and urgent appeals (Final and Binding Appeals) Reviews and Management for Medco's Coverage Authorization Programs	$5.00 per case (incremental to Coverage Authorization Program charge)

[3] Medco will retain 15% of any audit recoveries to offset expenses of this program.

[4] Pricing contingent upon participation in the associated Medco Program Guarantee. This pricing and Program Guarantee are based on acceptance of Medco's recommendations within drug categories and are subject to change based upon any applicable government legislation licensing requirements.

[5] Additional charges may be incurred for non-standard SPONSOR specific requirements, processing, and/or communications.

• Retail Refill Allowance Program Member Communications Materials	Quoted upon request
• Claims Detail Layout (CDL) recreate files	Quoted upon request
• SPONSOR's requests for claims data, Plan Design information, or production files for itself or its designees (subject to execution of Medco's confidentiality agreement)	Quoted upon request
• Requests for multiple data feeds	Additional fees per file, per cycle – quoted upon request.
• Data feeds to third party vendors on CD ROM	Additional fees per file, per cycle – quoted upon request

Note: Charge for additional services not listed above will be determined by Medco and quoted upon request.

5. IMPLEMENTATION ALLOWANCE

After ninety (90) days following full implementation of SPONSOR's Integrated Program and for the Initial Term of this Agreement, Medco will credit up to $4.00 per Primary Eligible Participant against future billings under SPONSOR's Program for documented expenses incurred and submitted by SPONSOR to Medco for the preparation and/or implementation of SPONSOR's Integrated Program (e.g., consulting fees, RFP preparation, or special communications associated with the Integrated Program roll-out). This credit will not be offset by any expenses incurred by Medco for the implementation of SPONSOR's Program.

6. BURCHFIELD SATISFACTION GUARANTEE

Medco shall develop a Burchfield Satisfaction Survey to measure performance criteria mutually agreed upon by Burchfield and Medco. The survey criteria shall be mutually agreed upon prior to the beginning of the first Contract Year under this Agreement and will be administered by Medco within ninety (90) days after the end of each Contract Year during the Initial Term of this Agreement. If those Burchfield employees who are member of the Rx Benefits Coalition staff do not rate Medco performance for such Contract Year on average of three (3) or better on a scale of 1 to 5 (5 being the best), Burchfield may assess a penalty in the amount of $60,000 per Contract Year. In the event that the aggregate Burchfield Satisfaction Survey results for the applicable Contract Year of all Rx Benefits Coalition member companies average three (3) or greater, then no such penalty will be applicable. Burchfield may request a meeting with Medco, which shall include senior member of the account management team to discuss performance improvement, if the Burchfield Satisfaction Survey is below an average of three (3) for any Contract Year.

7. FORMULARY

SPONSOR will be a participating plan sponsor in Medco's *Preferred Prescriptions* Formulary as set forth below for the term of this Agreement. SPONSOR will provide Medco with advance notice of each Group that will participate in the *Preferred Prescriptions* Formulary.

7.1 ***Preferred Prescriptions* Formulary** - The *Preferred Prescriptions* Formulary is a prescription drug formulary administered by Medco which lists FDA approved drugs that have been evaluated for inclusion on the *Preferred Prescriptions* Formulary. The drugs included on the *Preferred Prescriptions* Formulary will be modified by Medco from time to time as a result of factors including, but not limited to, medical appropriateness, manufacturer rebate arrangements, and patent expirations. Medco will implement Medco's formulary management programs, which may include cost containment initiatives, therapeutic interchange programs, communications with Eligible Persons, Participating Pharmacies and/or physicians (including communications regarding generic substitution programs), and financial incentives to Participating Pharmacies for their participation. Compliance with the *Preferred Prescriptions* Formulary and Medco's formulary management program will result in Formulary Rebates as set forth below. Medco reserves the

right to modify or replace the *Preferred Prescriptions* Formulary (including any modification or replacement, the "Formulary") and formulary compliance methods and cost containment initiatives consistent with good pharmacy practice. SPONSOR agrees that Medco will be the exclusive formulary administrator for SPONSOR's prescription drug benefit programs during the term of the Agreement. SPONSOR is authorized to use the Formulary only for its own Eligible Persons and only as long as the Program is in effect and administered by Medco.

7.2 **Rebates** - Medco and its subsidiaries receive formulary rebates from certain drug manufacturers as a result of the inclusion of those manufacturers' branded products on the Formulary ("Formulary Rebates"). Medco also receives additional rebates and/or fees from certain manufacturers for such products, which may take into account various factors, including the utilization of certain drugs within their respective therapeutic categories for Medco's book of business in aggregate as a result of various commitments, services, and programs, including, but not limited to, formularies, but excluding payments or fees from certain manufacturers related to drug-specific dispensing, shipping, and handling and other commitments, services and programs associated with Specialty Drugs dispensed by Medco ("Additional Rebates and Fees") Formulary Rebates and Additional Rebates and Fees are jointly referred to as "Total Rebates." Medco will provide SPONSOR with the greater of (i) 100% of the Total Rebates received by Medco based on the dispensing of each manufacturer's formulary drugs under SPONSOR's Program, less a Formulary management fee equal to the percentage set forth below of the Total Rebates received by Medco under the Program or (ii) the Guaranteed Rebates (as defined below) less a Formulary management fee equal to the percentage set forth below of the Guaranteed Rebates. This management fee will be retained by Medco under the Program. Total Rebates will be credited against future billings to SPONSOR under the Program one hundred eighty (180) days after the end of each calendar quarter. Provided SPONSOR has executed this Agreement. Total Rebates due SPONSOR under this Agreement that are received by Medco within eighteen (18) months after termination or expiration of this Agreement will be paid to SPONSOR. Total Rebates received thereafter will be retained by Medco.

Formulary Management Fee	Open & Incentive Formulary
Up to 30,000 lives in the Coalition	25.0%
30,001 to 90,000 lives in the Coalition	15.0%
90,001 plus lives in the Coalition	12.5%

7.3 **Guaranteed Rebates** - After each Contract Year during the Initial Term that SPONSOR participates in the Formulary, Medco will calculate SPONSOR's Total Rebates during such Contract Year. Provided SPONSOR complies fully with the Formulary and with the Formulary management programs implemented by Medco, if SPONSOR'S percentage share of Total Rebates for any Contract Year during the Initial Term are less than the sum of the amounts listed below less the applicable management fee Medco will credit such difference against future billings to SPONSOR under the Program one hundred eighty (180) days after the end of each Contract Year.

Open Formulary:

	Per Brand Claim		
Contract Year	**Retail 30 Day**		**Mail Order**
Year 1	$13.50		$39.92
Year 2&3	$14.58		$42.48

Open Formulary (with Preferred Drug Step Therapy):

	Per Brand Claim		
Contract Year	**Retail 30**		**Mail Order**

	Day		
Year 1	$15.18		$44.53
Year 2&3	$15.70		$46.13

Incentive Formulary:**

	Per Brand Claim		
Contract Year	**Retail 30 Day**		**Mail Order**
Year 1	$15.30		$42.45
Year 2&3	$16.54		$45.15

Incentive Formulary (with Preferred Drug Step Therapy):**

	Per Brand Claim		
Contract Year	**Retail 30 Day**		**Mail Order**
Year 1	$16.98		$47.05
Year 2&3	$17.66		$48.81

**The Guaranteed Formulary Rebates are contingent upon SPONSOR implementing a three tier formulary whose differential in copayment or its reasonably equivalent value for coinsurance between formulary and non-formulary drugs is not less than $15.00.

7.4 Upon review of SPONSOR's plan design and utilization data, specifically as they relate to SPONSOR's On-site pharmacy , Medco reserves the right to adjust the above Guaranteed Rebates if Medco concludes that either factor would have an adverse effect on the availability of Total Rebates or the Program Pricing Terms.

7.5 If a government action, change in law or regulation, change in the interpretation of law or regulation or action by any drug manufacturer or by SPONSOR has an adverse effect on the availability of Total Rebates or the Program Pricing Terms, Medco may modify, as applicable, the Total Rebates due SPONSOR and the Guaranteed Rebates or the Program Pricing Terms.

7.6 Any lines of SPONSOR's business, or any Group of Eligible Persons, for which SPONSOR funds less than 50% of the costs of Covered Drugs under the Plan Design will not be entitled to Formulary Rebates and Additional Rebates and Fees. Calculations and guarantees under Sections 8.2 and 8.3 will not include prescriptions dispensed for any such lines of business or Groups.

7.7 Preferred Drug Step Therapy Program – If elected by SPONSOR. SPONSOR's plan administered by Medco may include the Preferred Drug Step Therapy Program. The Preferred Drug Step Therapy Program is a formulary based overage review process that promotes therapeutically equivalent generic or preferred brand name drugs over non-formulary drugs unless and to the extent the treating physician provides clinical support for the non-preferred drug for Proton Pump Inhibiters and Selective Serotonin Reuptake Inhibitors.

8. INVOICE CREDIT

Medco will provide an invoice credit to SPONSOR in an amount up to $55,000 on the first claims invoice of the first contract year. This invoice credit is contingent upon this Agreement being fully executed.

DOCTORS
MEDICAL CENTER

MOSS ADAMS: AUDIT REPORT

Tab 9

Doctors Medical Center Management Authority, JPA Board

Chris Pritchard
Health Care Services Partner

Joelle Pulver
Health Care Services Senior Manager

(415) 956-1500

MOSS-ADAMS LLP

Auditor's Report

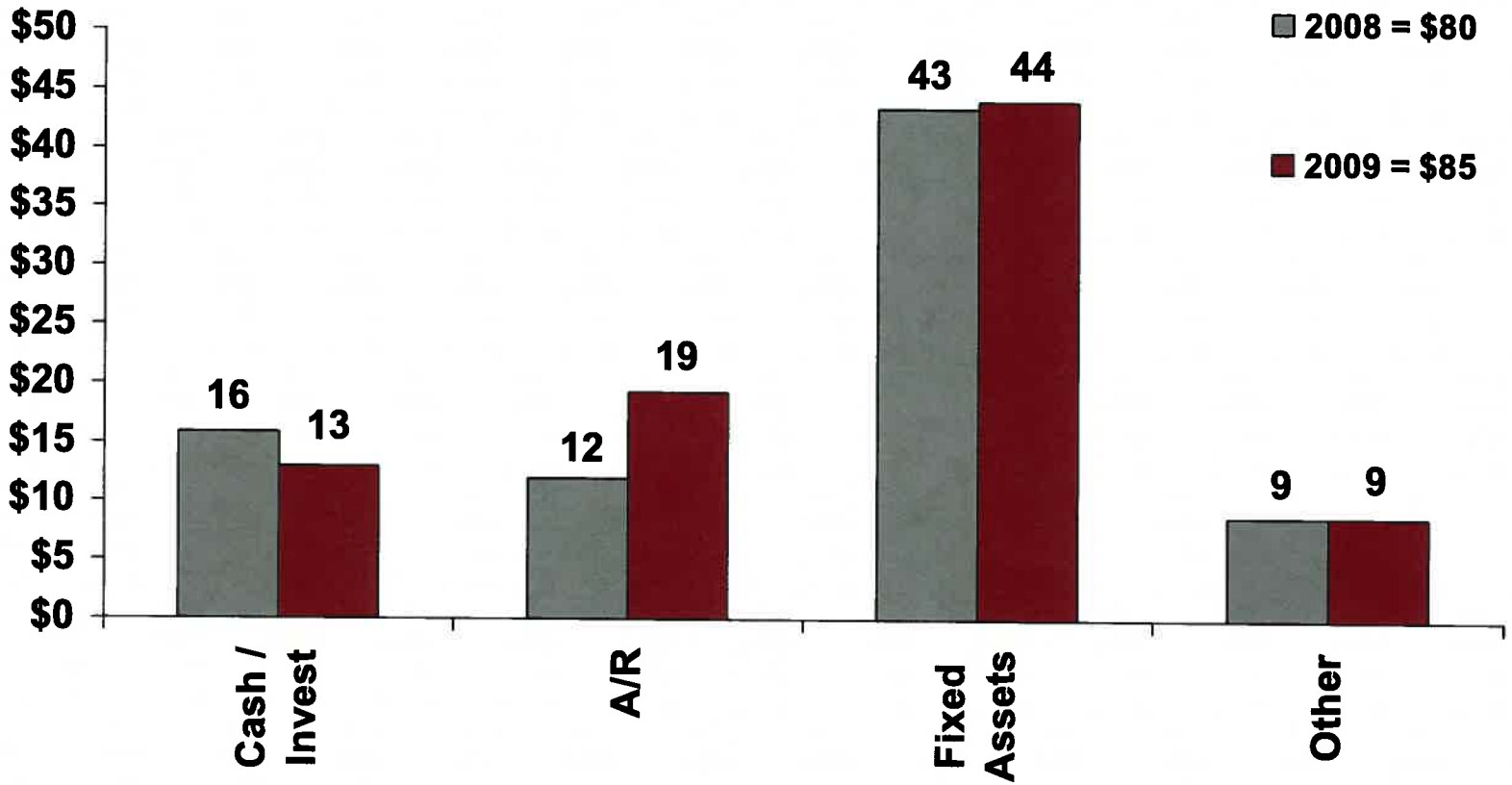
Unqualified Opinion

Financial statements are fairly presented in accordance with generally accepted accounting principles.

BALANCE SHEET

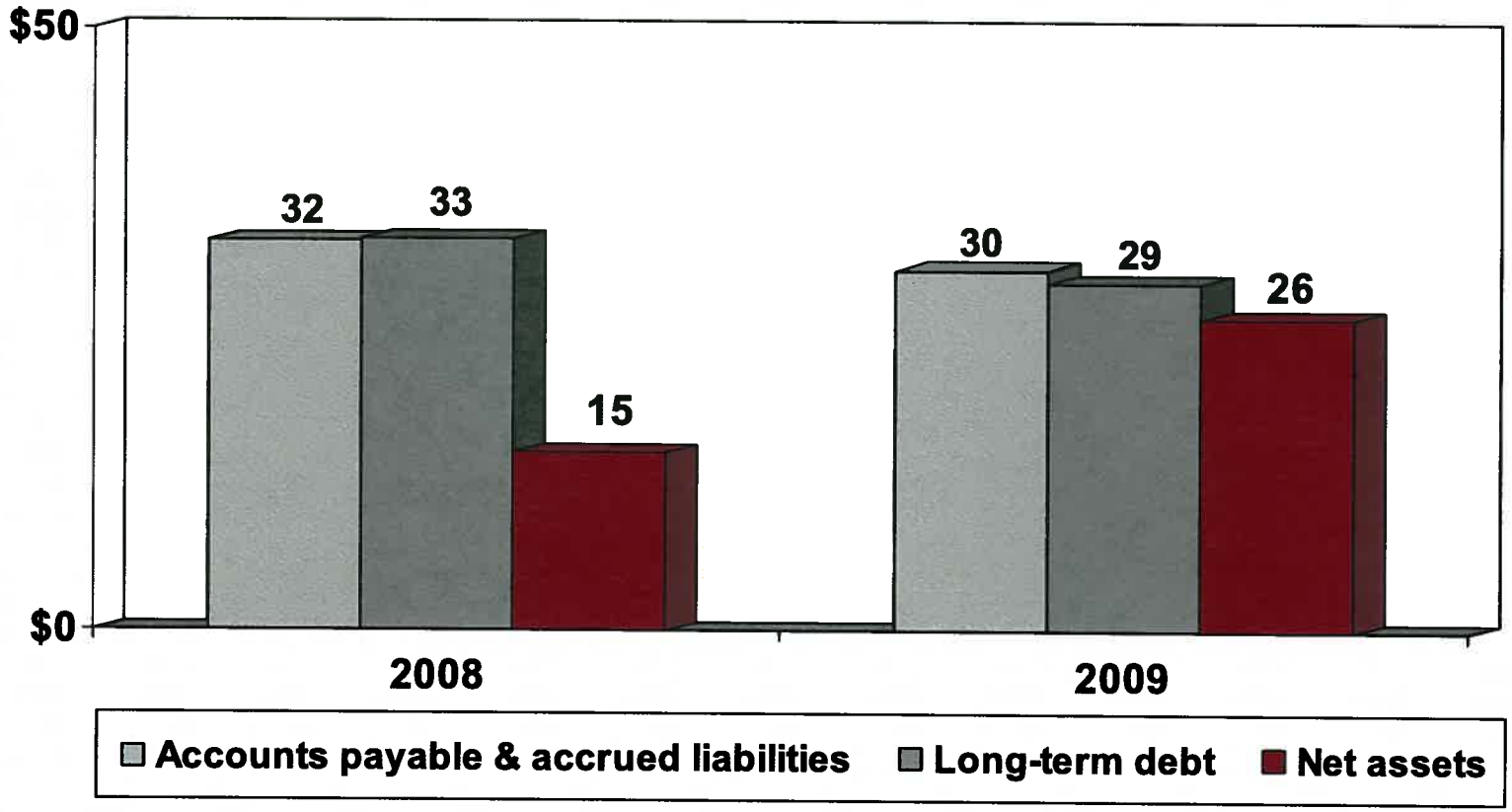
Asset Composition

(in millions)



Liabilities and Net Assets

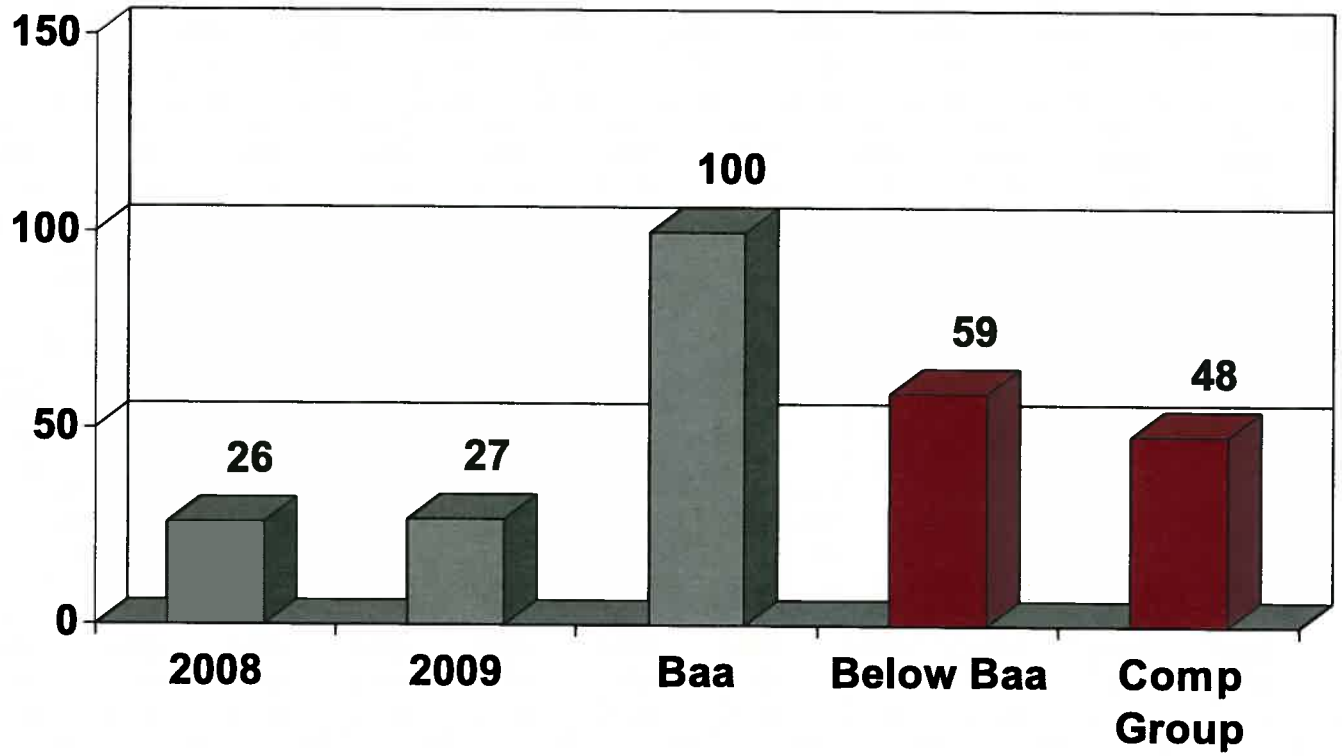
(in millions)



Days Cash and Investments

- Liquidity indicator
- Measures the ability of the hospital to sustain operations with existing cash
- The higher the number - the more cash reserves available
- (Unrestricted cash and investments plus funds designated for capital improvements x 365)/(total operating expenses – depreciation and amortization expenses)

Days Unrestricted Cash and Investments



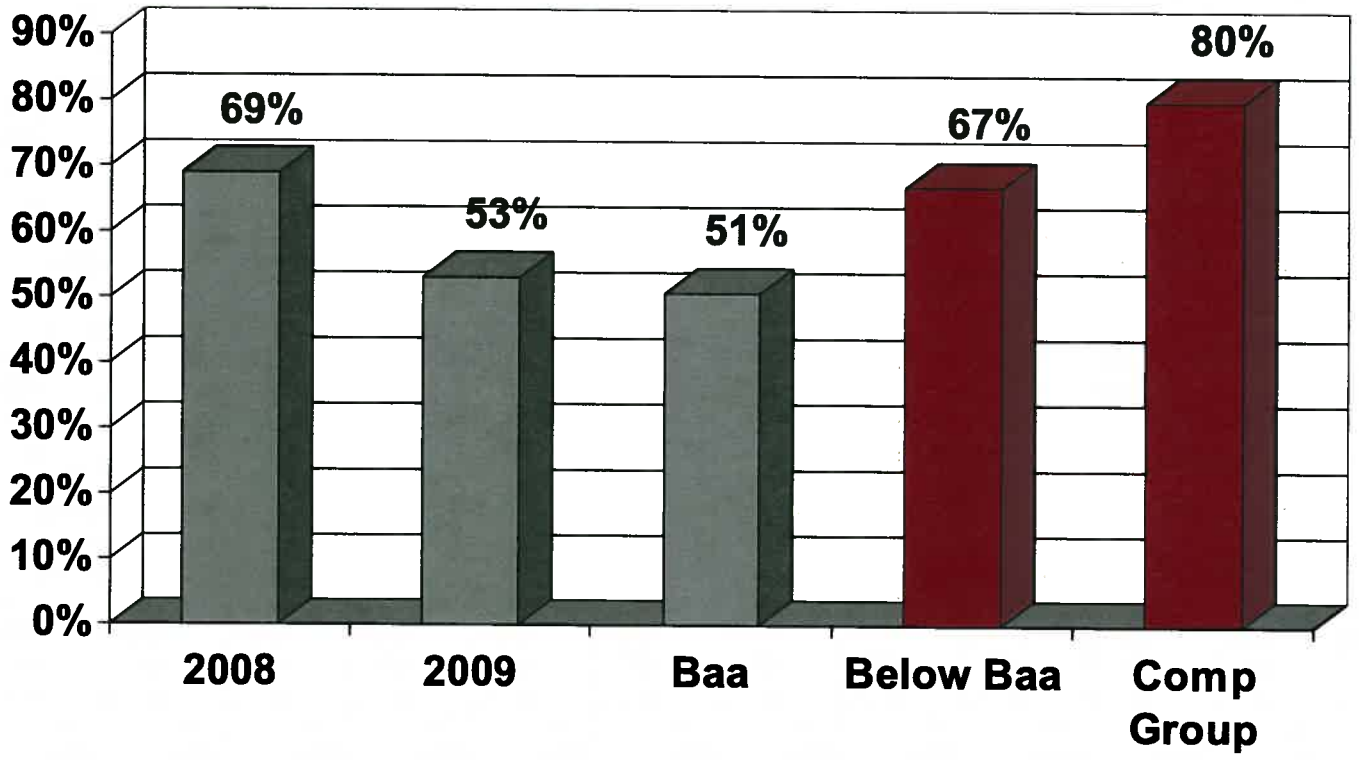
Moody's Health Care *

* Moody's Investors Service: *Fiscal Year 2008 Not-for-Profit Health Care Medians August 2009*

Debt to Capitalization

- Leverage indicator
- Indicates extent assets are financed with debt as opposed to paid for with cash
- Lower number indicates assets are "bought and paid for"
- (Long-term and short-term debt)/(long-term and short-term debt plus net assets)

Debt to Capitalization



*Moody's Health Care **

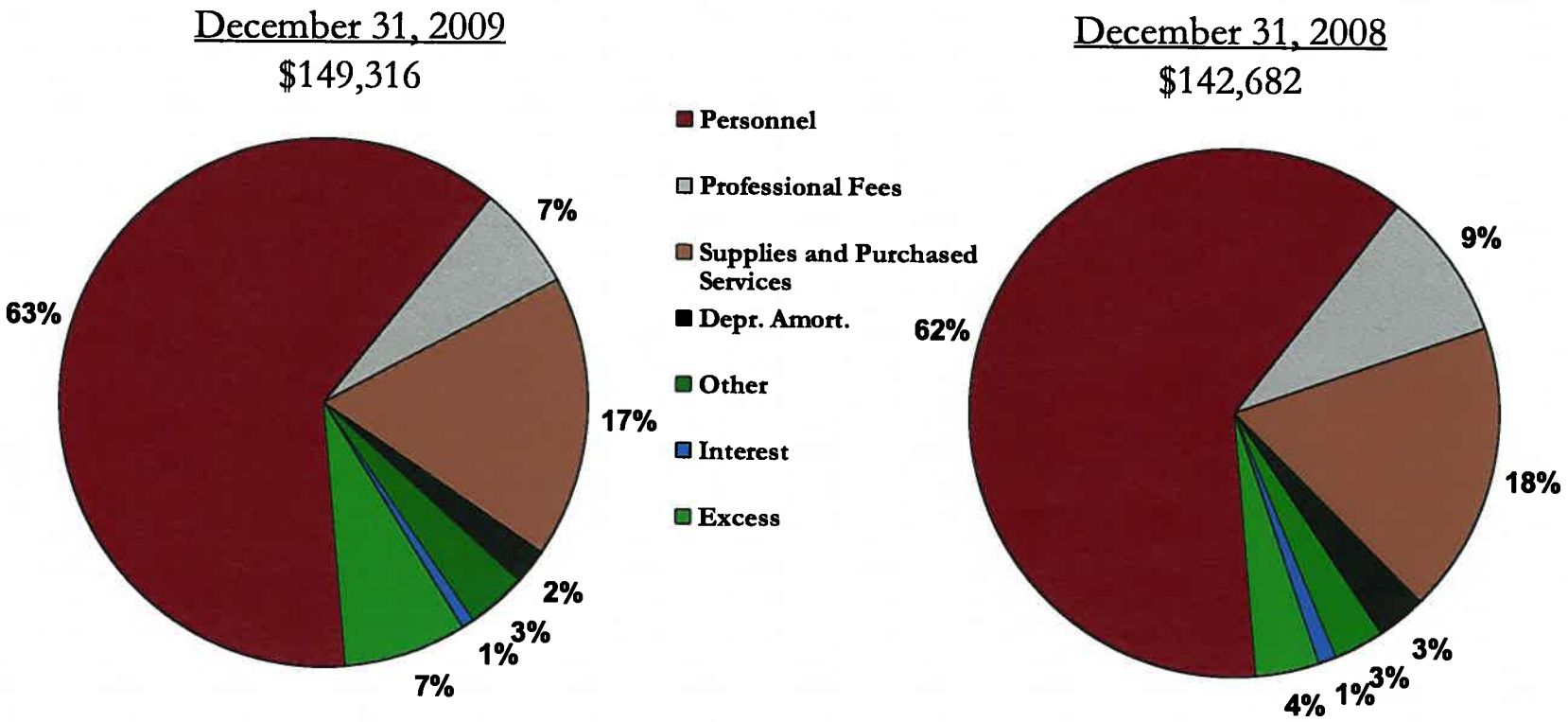
* Moody's Investors Service: *Fiscal Year 2008 Not-for-Profit Health Care Medians August 2009*

OPERATIONS

Income Statements (in thousands)

Year-to-Year Comparison

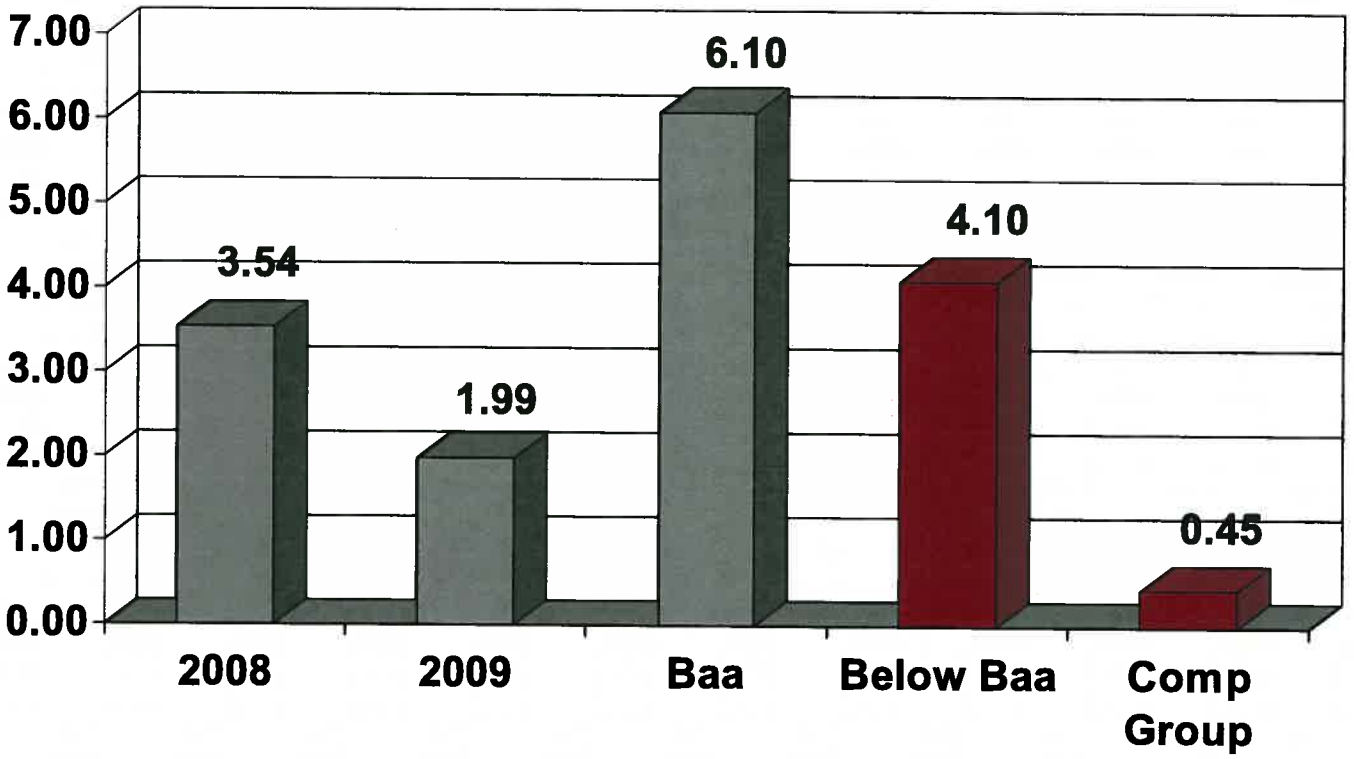
Total Revenue and Other Income



Debt to Cash Flow

- Profitability and leverage indicator
- Measures ability to generate ongoing cash flow to service debt
- Lower numbers indicate better ability to make debt payments
- (Long-term debt and short-term debt)/ (excess of revenues over expenses + depreciation expense)

Debt to Cash Flow



*Moody's Health Care **

* Moody's Investors Service: *Fiscal Year 2008 Not-for-Profit Health Care Medians August 2009*

Important Board Communications

- Significant accounting policies – SAS 114
- Accounting estimates are reasonable
- No issues discussed prior to our retention as auditors
- No disagreement with management
- Internal control items

QUESTIONS

DRAFT
3/31/10

WEST CONTRA COSTA HEALTHCARE DISTRICT

INDEPENDENT AUDITOR'S REPORT
AND
FINANCIAL STATEMENTS

DECEMBER 31, 2009 and 2008

CONTENTS

MANAGEMENT DISCUSSION AND ANALYSIS

Our discussion and analysis of West Contra Costa County Healthcare District's (the "District") financial performance provides an overview of the District's financial activities for the fiscal years ended December 31, 2009, 2008 and 2007. Please read it in conjunction with the District's financial statements, which begin on page 6.

Financial Highlights

- The District's net assets increased in 2009 from 2008 by $11.0 million or 74% after an increase in 2008 from 2007 of $18.1 million or 553%.
- The District reported operating income of $3.8 million in 2009 after operating losses in 2008 of $2.3 million and $18.2 million in 2007.
- The District's nonoperating revenues were $7.3 million in 2009 as compared to $7.7 million in 2008 and $7.7 million in 2007.

Using This Annual Report

The District's financial statements consist of three statements – a balance sheet; a statement of revenues, expenses, and changes in net assets; and a statement of cash flows. These financial statements and related notes provide information about the activities of the District, including resources held by the District but restricted for specific purposes by contributors, grantors, or enabling legislation.

The Balance Sheet and Statement of Revenues, Expenses, and Changes in Net Assets

Our analysis of the District's finances begins on page 1. One of the most important questions asked about the finances is, "Is the District as a whole better or worse off as a result of the year's activities?" The balance sheet and the statement of revenues, expenses, and changes in net assets report information about the District's resources and its activities in a way that helps answer this question. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All of the current year's revenues and expenses are taken into account regardless of when cash is received or paid.

These two statements report the District's net assets and changes in them. You can think of the District's net assets – the difference between assets and liabilities – as one way to measure the District's financial health, or financial position. Over time, increases or decreases in the District's assets are one indicator of whether its financial health is improving or deteriorating. You will need to consider other nonfinancial factors, however, such as changes in the District's patient base and measures of the quality of service it provides to the community, as well as local economic factors to assess the overall health of the District. Overall, the District is better off at December 31, 2009 than it was December 31, 2008.

The Statement of Cash Flows

The final required statement is the statement of cash flows. The statement reports cash receipts, cash payments, and net changes in cash resulting from operations, investing, and financing activities. It provides answers to such questions as "Where did cash come from?" "What was cash used for?" and "What was the change in cash balance during the reporting period?"

The District's Net Assets

The District's net assets are the difference between its assets and liabilities reported in the balance sheet on page 6. The net assets increased in 2009 by $11.0 million over 2008.

Table 1: Assets, Liabilities, and Net Assets

	2009	2008	2007
Assets			
Current assets	$ 39,577,000	$ 35,071,000	$ 27,908,000
Capital assets, net	44,033,000	43,318,000	44,575,000
Other noncurrent assets	1,228,000	1,266,000	10,500,000
Total Assets	84,838,000	79,655,000	82,983,000
Liabilities			
Current liabilities	31,906,000	27,409,000	44,987,000
Other	27,077,000	37,439,000	41,267,000
Total Liabilities	58,983,000	64,848,000	86,254,000
Net Assets (deficit)			
Invested in capital assets, net of related debt	18,667,000	17,550,000	35,377,000
Restricted expendable net assets	4,435,000	7,919,000	6,389,000
Unrestricted	2,753,000	(10,662,000)	(45,037,000)
Total Net Assets (deficit)	25,855,000	14,807,000	(3,271,000)
Total Net Assets and Liabilities	$ 84,838,000	$ 79,655,000	$ 82,983,000

A significant component of the change in the District's assets is the increase in patient accounts receivable. Net patient service revenue increased in 2009 by $7.0 million (5.3%), patient accounts receivable, net of estimated uncollectible amounts, increased by $7.2 million or 60.4% in 2009. In addition, net patient service revenue increased by $18.5 million or 16.2% in 2008 compared to 2007, while receivables decreased by $1.4 million or 10.6%. The increase in accounts receivable from 2008 to 2009 is due to several factors. At December 2008, the gross accounts receivable had a large amount of aged self pay acco ts and accounts older than 151 days. The self pay accounts were 100% reserved as uncollectable. During 2009, management put a significant amount of effort in resolving the self pay and 151 days plus accounts. The self pay accounts receivable was reduced during 2009 from a high of $33.2 million to a December 31, 2009 balance of $9.4 million, or 70.6%. Accounts older than 151 days were reduced from a high of $56.4 million to $21.2 million at December 31, 2009 or 61.5%. The cash collections goal on patient accounts for 2009 was $ 114 million. The actual cash collections were $117 million or $3 million over the goal. The Net Accounts Receivable increased by $10.5 million from 2008 to 2009. This increase is the result of decreases in Gross Accounts Receivable from 2008 to 2009 by $54.5 million, improvements in the age of accounts and the decrease in self pay accounts.

In 2009, the District also paid down its long term debt by $10.4 million, including a $3.4 million payment on the District's bankruptcy debt. The balance of the long term debt payments were to Contra Costa County and for the District's Bonds. The estimates from third party settlements increased in 2009. This was the result of a component of the Medicare payment calculation being updated. This caused management to revise Medicare cost report estimates back to 2007 cost reports. This was reflected in the 2009 balances only.

Table 2: Operating Results and Changes in Net Assets

	2009	2008	2007
Operating revenues			
Net patient service revenue	$ 139,576,000	$ 132,610,000	$ 114,102,000
Other operating revenue	1,149,000	1,117,000	1,558,000
Total operating revenues	140,725,000	133,727,000	115,660,000
Operating expenses			
Salaries and benefits	92,915,000	87,952,000	87,994,000
Supplies	18,275,000	19,800,000	17,395,000
Depreciation and amortization	3,511,000	3,503,000	3,545,000
Other operating expenses	22,251,000	24,760,000	24,885,000
Total operating expenses	136,952,000	136,015,000	133,819,000
Operating income (loss)	3,773,000	(2,288,000)	(18,159,000)
Nonoperating revenues (expenses):			
District tax revenue	8,591,000	8,955,000	8,833,000
Investment income	198,000	390,000	669,000
Interest expense	(1,514,000)	(1,624,000)	(1,836,000)
Total net nonoperating revenues	7,275,000	7,721,000	7,666,000
Excess of revenues over expenses (expenses over revenues)	11,048,000	5,433,000	(10,493,000)
Extraordinary gain – bankruptcy settlement	-	12,645,000	-
Increase (decrease) in net assets	11,048,000	18,078,000	(10,493,000)
Net assets (deficit) at beginning of the year	14,807,000	(3,271,000)	7,222,000
Net assets (deficit) at end of the year	$ 25,855,000	$ 14,807,000	$ (3,271,000)

In 2009, the District reported operating income of $3.8 million. Over the past 3 years, the District's management team was staffed with outside consultants. The main focus of the consultants was to bring the District out of bankruptcy. The consultants achieved that objective when the District emerged from bankruptcy in August 2008. During 2009, a full time management team was installed. The new team has much different objectives. Their objective is to transform the District from a bankruptcy minded facility to an on-going hospital that has a bright future. In 2009, the District took some major steps in this transition. These activities resulted in the improvements in operations and financial performance during 2009.

The following is a list of some of the objectives that were achieved in 2009:

Patient Care

- Changed from 12 hour RN shifts to 8 hour with estimated yearly savings of $3 million
- Established a new RN graduate program to attract local RNs
- Implemented wireless direct access to caregivers at bedside
- Joined IHI national collaborative on Transforming Care at Bedside
- Implemented Nursing Boot Camp for RN competencies
- Implemented the Verge software tracking system for real time Joint Commission compliance
- Initiated the installation of the Midas program for support of physician credentialing
- Continue clinical rotations for Touro University Medical Students
- 25 new high tech med surge beds and 10 new critical care beds with scales

Business Development & Growth

- Started Lung Clinic
- MRI imaging

- PET/CT scanning
- New ultrasound room
- Installed new radiology room
- Upgraded cancer therapy radiation treatment incorporating IMRT technology
- Three new anesthesia machines and monitors
- Three Lamines Eye Lasers, which give us more ophthalmologic laser treatment options

Accreditation, Regulatory & Life Safety

- DMC received 3 year accreditation from the Joint Commission
- DMC's laboratory received accreditation the Joint Commission
- Removed all deficiencies from CMS Conditions of Participation (Medicare)
- No life safety violations for entire hospital in accreditation survey
- Installed a New Power Transformer

Information Systems

- Major system upgrades to computer system applications:
- Implementation of clinical profile and care organizer
- Installation and implementation of wireless phones system ("ASCOM")
- Personalized the DMC Pre-Op assessment reports to improve physician satisfaction
- ANSI automation
- Horizon Business Insight ("HBI") scorecard for OP volumes by MD

Human Resources

- Union grievances reduced by 70%
- Re-established a comprehensive single employee HR file
- Re-constituted the benefits administration program with new broker- Keenan and Associates
- Upgrade to Kronos 6.1 have initiated implementation
- Developed an all RN nurse recruitment program

Outreach & Community Engagement

- Hosted three H1N1 vaccination clinics where almost 1,800 members of the community received the vaccine
- Hosted prostate screening events in the Cancer Center
- Hosted the annual Senior Health Fair event for West County Seniors
- Coordinated two community seasonal flu clinics for over 300 community residents
- Participated in numerous Community Health Fairs and Festivals
- Provided updates to West County City Councils
- DMC was the beneficiary of the San Pablo Rotary Club's annual fundraiser to benefit the Emergency Room waiting room remodeling project
- Hosted annual Diabetes Awareness Fair
- New Cancer Center community library
- Continued "Every Woman Counts" breast cancer detection program
- Continued several cancer support groups
- Continued monthly diabetes support group
- Participated in Robinsons Weeks Robinsons scholarship fundraiser dinner
- Participated in Brookside Community Health Center Annual Golf Tournament

The major reasons for the increase in operating income in 2009 from an operating loss in 2008 are directly related to the fact that operating revenue increased from $133.7 million to $140.7 million or $ 7 million (5.2 percent) while operating expenses increased from $136.0 million to $137.0 million or $1 million (0.7 percent.)

The primary reasons for the increase in operating income are:

- Increase in net patient revenues of $7.0 million or 5.3 percent. This is primarily due to the growth in outpatient activity. Gross outpatient charges increased by $11.2 million (5.1 percent.)
- Decrease in nursing overtime from 2008 to 2009 by $1.5 million (18 percent). This is primarily due to full implementation of a staff productivity system. Staffing is monitored on a daily basis in order to ensure proper management of labor cost. Another factor that added to this was the conversion from 12 hour to 8 hour shifts and the elimination of mandatory nursing overtime.
- Decrease in overall supply cost of $1.5 million or (7.6 percent). This is primarily due to appropriate contract compliance with the District's group purchasing organization vendors.
- Decrease in professional fees of $3.5 million or (26.4 percent). This is due to the conversion of contracted management to full time employed management staff.

The District sometimes provides care for patients who have little or no health insurance or other means of repayment. As discussed, this service to the community is consistent with the goals established for the District when it was established. The cost of services provided to these patients increased by $584,800 in 2009 compared to 2008. Because there is no expectation of repayment, charity care is not reported as patient service revenues of the district.

Nonoperating Revenues and Expenses

Nonoperating revenues consist primarily of property taxes levied by the District and interest revenue and investment earnings. These amounts are consistent between 2009, 2008, and 2007.

The District's Cash Flows

Changes in the District's cash flows are consistent with changes in operating losses and nonoperating revenues and expenses, discussed earlier.

Capital Assets

At the end of 2009, the District had $44.0 million invested in capital assets, net of accumulated depreciation, as detailed in note 7 to the financial statements. In 2009, the District purchased new equipment costing $3.5 million.

Contacting The District's Financial Management

This financial report is designed to provide our patients, suppliers, taxpayers, and creditors with a general overview of the District's finances and to show the District's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the District's Chief Financial Officer's office at Doctors Medical Center, 2000 Vale Road, San Pablo, CA 94806.

INDEPENDENT AUDITOR'S REPORT

The Board of Directors
West Contra Costa Healthcare District

We have audited the accompanying balance sheet of West Contra Costa Healthcare District (the "District") as of December 31, 2009 and the related statements of revenues, expenses, and changes in net assets and cash flows for the year then ended. These financial statements are the responsibility of the District's management. Our responsibility is to express an opinion on these financial statements based on our audit. The financial statements of West Contra Costa Healthcare District as of and for the year ended December 31, 2008 were audited by another auditor whose opinion dated April 10, 2009 expressed an unqualified opinion on those financial statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of West Contra Costa Healthcare District as of December 31, 2009, and the changes in its financial position and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Management's discussion and analysis on pages 1 through 5 is not a required part of the financial statements but is supplementary information required by the accounting principles generally accepted in the United States of America. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

San Francisco, California

FINANCIAL STATEMENTS

WEST CONTRA COSTA HEALTHCARE DISTRICT
BALANCE SHEETS
December 31, 2009 and 2008

	2009	2008
ASSETS		
Current assets		
Cash and cash equivalents	$ 7,666,000	$ 7,218,000
Patient accounts receivable, net of estimated uncollectibles of $9,320,000 and $31,497,000 for 2009 and 2008 respectively	19,157,000	11,922,000
Other receivables	5,367,000	5,125,000
Current portion of board designated and trusteed assets	4,721,000	7,927,000
Supplies	2,056,000	1,886,000
Prepaid expenses and deposits	610,000	993,000
Total current assets	39,577,000	35,071,000
Board designated assets, net of current portion	642,000	639,000
Capital assets, net of accumulated depreciation	44,033,000	43,318,000
Other assets	586,000	627,000
Total assets	$ 84,838,000	$ 79,655,000
LIABILITIES AND NET ASSETS		
Current liabilities		
Current maturities of long-term debt	$ 3,634,000	$ 3,526,000
Accounts payable and accrued expenses	11,828,000	11,947,000
Accrued payroll and related liabilities	9,403,000	8,110,000
Other current liabilities	3,570,000	3,180,000
Estimated third-party payor settlements	3,471,000	646,000
Total current liabilities	31,906,000	27,409,000
Debt borrowings, net of current maturities	25,306,000	28,964,000
Other long-term liabilities	1,771,000	8,475,000
Total liabilities	58,983,000	64,848,000
Net assets		
Invested in capital assets, net of related debt	18,667,000	17,550,000
Restricted expendable	4,435,000	7,919,000
Unrestricted	2,753,000	(10,662,000)
Total net assets	25,855,000	14,807,000
Total liabilities and net assets	$ 84,838,000	$ 79,655,000

See accompanying notes.

WEST CONTRA COSTA HEALTHCARE DISTRICT
STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET ASSETS
Years Ended December 31, 2009 and 2008

	2009	2008
Operating revenues		
Net patient service revenue (net of provision for bad debts of $4,985,000 in 2009 and $28,176,000 in 2008)	$ 139,576,000	$ 132,610,000
Other operating revenue	1,149,000	1,117,000
Total operating revenues	140,725,000	133,727,000
Operating expenses		
Salaries and wages	64,907,000	60,377,000
Employee benefits	28,008,000	27,575,000
Professional fees	9,736,000	13,227,000
Supplies	18,275,000	19,800,000
Purchased services	7,151,000	6,547,000
Rentals and leases	1,178,000	1,069,000
Depreciation and amortization	3,475,000	3,695,000
Other operating expenses	4,222,000	3,725,000
Total operating expenses	136,952,000	136,015,000
Operating income (loss)	3,773,000	(2,288,000)
Nonoperating revenues (expenses):		
District tax revenue	8,591,000	8,955,000
Investment income	198,000	390,000
Interest expense	(1,514,000)	(1,624,000)
Total net nonoperating revenues	7,275,000	7,721,000
Excess of revenues over expenses	11,048,000	5,433,000
Extraordinary gain – bankruptcy settlement	-	12,645,000
Increase in net assets	11,048,000	18,078,000
Net assets (deficit) beginning of the year	14,807,000	(3,271,000)
Net assets end of the year	$ 25,855,000	$ 14,807,000

See accompanying notes.

WEST CONTRA COSTA HEALTHCARE DISTRICT
STATEMENTS OF CASH FLOWS
Years Ended December 31, 2009 and 2008

	2009	2008
Cash flows from operating activities:		
Cash received from patients and third-parties on behalf of patients	$ 131,891,000	$ 136,738,000
Cash received from operations, other than patient services	907,000	1,801,000
Cash payments to suppliers and contractors	(40,570,000)	(56,303,000)
Cash payments to employees and benefits programs	(91,622,000)	(91,909,000)
Net cash provided by (used in) operating activities	606,000	(9,673,000)
Cash flows from noncapital financing activities:		
Extraordinary item – bankruptcy settlement	-	12,645,000
District tax revenues to support operations	5,654,000	5,652,000
Net cash provided by noncapital and related financing activities	5,654,000	18,297,000
Cash flows from capital and related financing activities:		
Payments on county loan	(2,937,000)	(3,396,000)
Purchase of capital assets	(4,149,000)	(2,396,000)
District tax revenues levied for debt service	2,937,000	3,303,000
Principal payments on debt borrowings	(3,550,000)	(3,875,000)
Interest payments on debt borrowings	(1,514,000)	(1,624,000)
Net cash used in capital and related financing activities	(9,213,000)	(7,988,000)
Cash flows from investing activities:		
Proceeds from sale of investments	3,203,000	964,000
Interest and dividends received from investments	198,000	390,000
Net cash provided by investing activities	3,401,000	1,354,000
Net increase in cash and cash equivalents	448,000	1,990,000
Cash and cash equivalents at beginning of year	7,218,000	5,228,000
Cash and cash equivalents at end of year	$ 7,666,000	$ 7,218,000
Reconciliation of operating income (loss) to net cash provided by (used in) operating activities:		
Operating income (loss)	$ 3,773,000	$ (2,288,000)
Adjustments to reconcile operating income (loss) to net cash provided by operating activities:		
Depreciation and amortization of other assets	3,475,000	3,695,000
Provision for bad debts	4,985,000	28,176,000
Changes in operating assets and liabilities:		
Patient accounts receivables	(15,495,000)	(23,569,000)
Other receivables	(242,000)	684,000
Supplies	(170,000)	473,000
Prepaid expenses and deposits	383,000	265,000
Accounts payable and accrued expenses	3,156,000	(3,919,000)
Accrued payroll and related liabilities	1,293,000	(3,957,000)
Other liabilities related to operating activities	(3,377,000)	(8,754,000)
Estimated third-party payor settlements	2,825,000	(479,000)
Net cash provided by (used in) operating activities	$ 606,000	$ (9,673,000)

See accompanying notes.

NOTE 1 – ORGANIZATION AND ACCOUNTING POLICIES

Reporting Entity – West Contra Costa Healthcare District (the "District") is a public agency organized under Local Hospital District Law as set forth in the Health and Safety Code of the State of California. The District is a political subdivision of the State of California and is not subject to federal or state income taxes. The District was formed in 1948 for the purpose of building and operating a hospital to benefit the residents of West Contra Costa County. The District is governed by a Board of Directors elected from within the healthcare district to specified terms of office. The District operates a full-service acute care facility and provides services to both inpatients and outpatients. The District also provides sub-acute and skilled nursing care. The District provides health care services primarily to individuals who reside in the local geographic area. The District has a contractual relationship with the Contra Costa County to provide management oversight. The Doctors Medical Center Management Authority ("JPA") is the result of a Joint Powers Agreement between the West Contra Costa Healthcare District and Contra Costa County.

Basis of Preparation –The District uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on Governmental Accounting Standards Board ("GASB") Statement Number 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities that Use Proprietary Fund Accounting*, as amended, the District has elected to apply the provisions of all relevant pronouncements as the Financial Accounting Standards Board ("FASB"), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

Use of Estimates – The preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents – The District considers cash and cash equivalents to include certain investments in highly liquid debt instruments, when present, with an original maturity of three months or less or subject to withdrawal upon request.

Patient Accounts Receivable – Patient accounts receivable consist of amounts reimbursable by various governmental agencies and insurance companies through the assignment process and private patients. The District manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectability and providing for allowances on their accounting records for estimates contractual adjustments and uncollectible accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

Investments in Marketable Securities – Investments in marketable securities consist primarily of short-term interest-bearing certificates of deposit, money market funds and mutual funds and are include assets held by trustees under indenture agreements and designated assets set aside by the Board of Directors for future funding of certain District obligations.

Supplies – Inventories are stated at cost, which is determined using the first-in, first-out method.

Capital Assets – Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Purchases over $1,000 are capitalized. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 30 years for buildings and improvements, and 3 to 10 years for equipment. Leasehold improvements are amortized using the straight-line method over the shorter of the lease term or the estimated useful life of the related assets. The District periodically reviews its capital assets for value impairment. As of December 31, 2009 and 2008, the District has determined that no capital assets are impaired.

Other Assets – Other assets include debt issuance costs. Debt issuance costs incurred in connection with the issuance of tax-exempt bonds have been deferred and are being amortized over the term of the bonds using a straight-line method.

Costs of borrowing – Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. None of the District's interest cost was capitalized for years ended December 31, 2009 and 2008.

Compensated Absences – District employees earn vacation benefits at varying rates depending on years of service. Employees also earn sick leave benefits based on varying rates depending on years of service. Both benefits can accumulate up to specified maximum levels. Employees are not paid for accumulated sick leave benefits if they leave either upon termination or before retirement. However, accumulated vacation benefits are paid to an employee upon either termination or retirement. Accrued vacation and sick leave liabilities as of December 31, 2009 and 2008 are $2,812,700 and $2,383,000, respectively.

Risk Management – The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Risk Retention Plans – The District maintains professional liability insurance on a claims-made basis, with liability limits of $500,000 per claim, and which is subject to a $25,000 deductible. Additionally, the District is self-insured for workers' compensation claims, with a self-insured retention of $350,000 per occurrence, and has excess insurance coverage for the portion of each occurrence in excess of $350,000. In the case of employee health coverage, the District is self-insured for those claims. Management estimates of uninsured losses for professional liability, workers' compensation and employee health coverage have been accrued as liabilities in the accompanying financial statements.

Net Assets – Net assets of the District are classified in three components. Net assets invested in capital assets net of related debt consist of capital assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. Restricted expendable net assets are noncapital net assets that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District, including amounts deposited with trustees as required by revenue bond indentures, discussed in Note 3. Unrestricted net assets are remaining net assets that do not meet the definition of invested in capital assets net of related debt or restricted.

Net Patient Service Revenue – Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered, and adjusted in future periods as final settlements are determined

Charity Care – The District accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the District. Essentially, these policies define charity services as those services for which no payment is anticipated. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Charity care amounts are included in net patient revenues in the financial statements.

Uncollectible Accounts – The District provides care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. A provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible.

Grants and Contributions – From time to time, the District receives grants from various governmental agencies and private organizations. The District also receives contributions from related foundation and auxiliary organizations, as well as from individuals and other private organizations. Revenues from grants and contributions are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either operating purposes or capital acquisitions. These amounts, when recognized upon meeting all requirements, are reported as components of the statement of revenues, expenses and changes in net assets.

Operating Revenues and Expenses – The District's statement of revenues, expense and changes in net assets distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, which is the District's principal activity. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Nonoperating revenues and expenses are those transactions not considered directly linked to providing health care services.

Income Taxes – The District operates under the purview of the Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to state or federal taxes on income.

Property taxes – The authority received approximately 5.8 percent in 2009 and 6.3 percent in 2008 of its financial support from property taxes. These funds were used as follows:

	2009	2008
Used to support operations	$ 5,654,000	$ 5,652,000
Levied for debt service	2,937,000	3,303,000

Property taxes are levied by the County on the District's behalf on January 1 and are intended to finance the District's activities of the same calendar year. Amounts levied are based on assessed property values as of the preceding July 1. Property taxes are considered delinquent on the day following each payment due date. Property taxes are recorded as nonoperating revenue by the District when they are earned.

Reclassifications – Certain amounts in the 2008 financial statements have been reclassified to conform to the 2009 presentation.

New Accounting Pronouncements – The FASB issued a statement for subsequent events which applies to interim or annual financial periods ending after June 15, 2009. The objective is to establish general standards of accounting for and disclosures of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. This statement sets forth the period after the balance sheet date during which management should evaluate events or transactions that may occur for potential recognition or disclosure in the financial statements, the circumstances under which the entity should recognize events or transactions occurring after the balance sheet date, and the disclosures that an entity should make about events or transactions that occurred after the balance sheet date. The Distritct has implemented the statement for the fiscal year ended December 31, 2009, as included in Note 11.

In June 2009, the FASB issued "The FASB Accounting Standards Codification and the Hierarchy of Generally Accepted Accounting Principles." The Codification establishes one level of authoritative GAAP and is effective for annual financial statements with fiscal year ends ending after September 15, 2009. Adoption of the Codification did not have a significant impact on the District's financial statements.

NOTE 2 – CASH AND CASH EQUIVALENTS, BOARD DESIGNATED AND TRUSTEED ASSETS

As of December 31, 2009 and 2008 the District had deposits invested in various financial institutions in the form of cash and cash equivalents including amounts classified as board designated assets amounting to $13,029,000 and $15,784,000, respectively. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code ("CGC"), except for $250,000 per account that is federally insured.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the District's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the District's deposits. California law also allows financial institutes to secure District deposits by pledging first trust deed mortgage notes having a value of 150% of the District's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the District.

The composition of board designated and trusteed assets at December 31, 2009 and 2008, is set forth in the following table. Investments are stated at fair value.

	2009	2008
Board designated		
Cash and cash equivalents	$ 920,000	$ 639,000
Certificates of deposit	1,331,000	$ 1,691,000
Money market/mutual funds	13,000	13,000
Held by trustee under indenture agreement		
Money market/mutual funds	3,099,000	6,223,000
	$ 5,363,000	$ 8,566,000

Investment income and gains for assets limited as to use, cash equivalents are comprised of the following for the years ending December 31, 2009 and 2008.

	2009	2008
Investment income		
Interest and dividend income	$ 119,000	$ 149,000
Total	$ 119,000	$ 149,000

NOTE 3 – NET PATIENT SERVICE REVENUES AND REIMBURSEMENT PROGRAMS

The District renders services to patients under contractual arrangements with the Medicare and Medi-Cal programs, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"). Patient service revenues from Medicare approximate 50% and 51% of gross patient service revenues, whereas patient service revenues from Medi-Cal approximate 23% and 20% for the years ended December 31, 2009 and 2008 respectively.

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, fee schedules, prepaid payments per member, and per diem payments or a combination of these methods. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated settlements under reimbursement agreements with third-party payors.

Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. Inpatient nonacute services related to Medicare beneficiaries are paid based on a cost-reimbursement methodology through March 31, 2004. Inpatient nonacute services subsequent to April 1, 2004, are paid at prospectively determined rates per discharge. Payments for outpatient services are based on a stipulated amount per diagnosis. The District is reimbursed for cost reimbursable items at a tentative rate, with final settlements determined after submission of annual cost reports by the District and audits thereof by the Medicare fiscal intermediary. The effect of updating prior year estimates for Medicare and other liabilities was to increase 2009 and 2008 net operating income by $874,000 and $837,000 respectively. The District's cost reports have been audited by the Medicare fiscal intermediary through 2008.

Medicare accounts for approximately 61% and 51% of the District's net patient service revenues whereas Medi-Cal revenue accounts for approximately 15% and 9% for the years ended December 31, 2009 and 2008, respectively. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change in the near term.

NOTE 4 – CONCENTRATION OF CREDIT RISK

The District grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the District and management does not believe that there are any credit risks associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the District. The District's policy is to maintain a 100% reserve for all private pay patient accounts receivables outstanding aged over 240 days. Concentration of patient accounts receivable at December 31, 2009 and 2008, were as follows:

	2009	2008
Medicare	42%	56%
Medi-Cal and Medi-Cal pending	35%	18%
Other third-party payors	23%	26%
Total	100%	100%

NOTE 5 – OTHER RECEIVABLES

Other receivables as of December 31, 2009 and 2008 were comprised of the following:

	2009	2008
Advances to physicians, notes and related receivables	$ 499,000	$ 413,000
Deposits	360,000	333,000
Refunds and rebates receivable	504,000	61,000
Rent receivable	-	29,000
California medical assistance commission ("CMAC") receivable	4,000,000	4,000,000
Other	4,000	289,000
Net other receivables	$ 5,367,000	$ 5,125,000

Advances to physicians are comprised of physician income guarantees and/or business loans to those physicians requiring assistance to begin a local practice. The District has entered into agreements with certain physicians whereby the District guarantees their income for a specified period of time. These agreements are structured so that if a physician maintains a practice in the area for a specified period of time, the income guarantee advances are forgiven.

NOTE 6 – CHARITY CARE

The amount of charges forgone for services and supplies furnished under the District's charity care policy aggregated approximately $46,649,000 and $20,491,000 in 2009 and 2008, respectively.

NOTE 7 – CAPITAL ASSETS

Capital assets as of December 31, 2009 were comprised of the following:

	Balance at December 31, 2008	Additions	Retirements & Adjustments	Balance at December 31, 2009
Capital assets not being depreciated				
Land and land improvements	$ 12,090,000	$ -	$ -	$ 12,090,000
Construction-in-progress	642,000	638,000	-	1,280,000
	12,732,000	638,000	-	13,370,000
Capital assets being depreciated				
Buildings and improvements	16,343,000	588,000	-	16,931,000
Equipment	29,119,000	2,923,000	(186,000)	31,856,000
	45,462,000	3,511,000	(186,000)	48,787,000
Totals at historical cost	58,194,000	4,149,000	(186,000)	62,157,000
Less accumulated depreciation	(14,876,000)	(3,434,000)	186,000	(18,124,000)
Total capital assets, net	$ 43,318,000	$ 715,000	$ -	$ 44,033,000

Capital assets as of December 31, 2008 were comprised of the following:

	Balance at December 31, 2007	Additions	Retirements & Adjustments	Balance at December 31, 2008
Capital assets not being depreciated				
Land and land improvements	$ 12,091,000	$ -	$ (1,000)	$ 12,090,000
Construction-in-progress	950,000	-	(308,000)	642,000
	13,041,000	-	(309,000)	12,732,000
Capital assets being depreciated				
Buildings and improvements	16,112,000	259,000	(28,000)	16,343,000
Equipment	28,545,000	2,137,000	(1,563,000)	29,119,000
	44,657,000	2,396,000	(1,591,000)	45,462,000
Totals at historical cost	57,698,000	2,396,000	(1,900,000)	58,194,000
Less accumulated depreciation	(13,123,000)	(3,461,000)	1,708,000	(14,876,000)
Total capital assets, net	$ 44,575,000	$ (1,065,000)	$ (192,000)	$ 43,318,000

Future construction commitments of approximately $1,615,000 exist for the tenant improvements at the San Pablo Outpatient center.

NOTE 8 – DEBT BORROWINGS

A schedule of changes in the District's debt borrowings for the year ended December 31, 2009 is as follows:

	December 31, 2008	Additions	Reductions	December 31, 2009
Notes payable:				
American Savings	$ 39,000	$ -	$ (3,000)	$ 36,000
Blue Cross	-	-	-	-
Bonds payable:				
Certificates of participation	24,965,000	-	(1,321,000)	23,644,000
Revenue bonds	2,877,000	-	(556,000)	2,321,000
Capital leases- equipment	4,609,000	-	(1,670,000)	2,939,000
	$ 32,490,000	$ -	$ (3,550,000)	$ 28,940,000

A schedule of changes in the District's debt borrowings, for the year ended December 31, 2008 is as follows:

	December 31, 2007	Additions	Reductions	December 31, 2008
Notes payable:				
American Savings	$ 43,000	$ -	$ (4,000)	$ 39,000
Blue Cross	450,000	-	(450,000)	-
Bonds payable:				
Certificates of participation	25,680,000	-	(715,000)	24,965,000
Revenue bonds	3,937,000	-	(1,060,000)	2,877,000
Capital leases- equipment	6,255,000	-	(1,646,000)	4,609,000
	$ 36,365,000	$ -	$ (3,875,000)	$ 32,490,000

The terms and due dates of the District's debt borrowings, including capital lease obligations, at December 31, 2009, are as follows:

- America Savings note payable dated September 1986, interest at 9.5%, maturing November 2015, principal payable in annual amounts ranging from 4,000 in 2010 to $6,000 in 2015, secured by property.

- Series 2004 Certificates of Participation dated July 2004, plus unamortized bond premium of $470,000, principal payable in annual installments ranging from $755,000 in 2010 to $1,795,000 in 2029, interest at stated coupon rates ranging from 2.0% to 5.5%, payable annually and collateralized by a pledge of the District's parcel tax revenues. Management believes the District is in compliance with the financial covenants and financial reporting requirements as specified in the Indenture Trust Agreement.

- Series 2004 revenue bonds dated December 2004, with principle payable in semi-annual installments of $565,000 to $596,000 until July 2011, interest at the stated coupon rate of 3.65%, payable semi-annually. Management believes the District is in compliance with the financial covenants and financial reporting requirements as specified in the Indenture Trust Agreement.

- Equipment under capital leases at various dates in 2009 and 2008, maturing at various dates through June 2011, with interest ranging from 3.05% to 8.0%.

Aggregate principal maturities on debt borrowings, based on scheduled maturities are as follows:

	Debt Borrowings		Capital Lease Obligations	
Year Ending December 31:	Principal	Interest	Principal	Interest
2010	$ 1,895,000	$ 1,196,000	$ 1,739,000	$ 109,000
2011	2,005,000	1,130,000	1,209,000	25,000
2012	824,000	1,094,000	5,000	3,000
2013	854,000	1,066,000	6,000	2,000
2014	884,000	1,036,000	6,000	2,000
2015-2019	4,970,000	4,628,000	6,000	1,000
2020-2024	6,332,000	3,262,000	-	-
2025-2029	8,205,000	1,383,000	-	-
	$ 25,969,000	$ 14,795,000	$ 2,971,000	$ 142,000

The fair values for debt borrowings (including capital lease obligations), are estimated using discounted cash flow analyses, based on the District's current incremental borrowing rates for similar types of borrowing arrangements. As of December 31, 2009 and 2008, the fair values of debt borrowings approximated their carrying values

NOTE 9 – RETIREMENT PLANS

The District offers two defined contribution savings plans intended to qualify under section 457(b) of the Internal Revenue Code ("IRC"). The plans are destined to provide participants with a means to defer a portion of their compensation for retirement and to provide benefits in the even to of death, disability, or financial hardship. The plans cover both former and current employees of the District who meet certain eligibility requirements. The District is the administrator of the plans and has delegated certain responsibilities for the operation and administration of the plans to outside third-party trustees. Under the plans employer contributions are discretionary. The District has not contributed to the plans since 2007.

The District also offers two Employer Contributory Tax Deferred Annuity Plans intended to qualify under section 403(b) and 457 of the IRC. The plans are designed to provide participants with a means to defer a portion of their compensation for retirement and to provide benefits in the event of death, disability, or financial hardship. The plan covers employees of the District, who meet certain eligibility requirements. Under the plan, the District may make matching contributions up to 5.0% of the participant's annual compensation to the plan. The District contributed $3,527,000 and $3,776,000 to the plan in 2009 and 2008, respectively.

The District also provides a non-contributory single-employer defined benefit pension plan. The plan covers all eligible employees of the previous Brookside Hospital. Brookside Hospital was the previous name of Doctors Medical Center prior to the Tenet purchase. The Plan provides retirement and death benefits to plan members and beneficiaries based on each employee's years of service and annual compensation. No new employees have been enrolled in the plan since 1996. There are no current District employees participating in the plan.

Funding Policy – The District is required to contribute the actuarially determined amounts necessary to fund the benefits for its participants. Active plan participants are not required to contribute. The actuarial methods and assumptions used are those adopted by the District.

Annual Pension Cost and Net Pension Obligation – The plan's annual pension cost and net pension obligation for the current and prior year were as follows:

	2009	2008
Annual required contribution	$ 460,000	$ 85,000
Interest on net pension obligation	(10,000)	(18,000)
Adjustment to annual required contribution	15,000	25,000
Annual pension cost	465,000	92,000
Net increase in pension obligation	$ 465,000	$ 92,000
Prepaid pension asset beginning of year	$ (133,000)	$ (295,000)
Net increase in pension obligation	(465,000)	(92,000)
Actuarial gain (loss)	929,000	254,000
Net pension obligation (prepaid pension asset) end of year	$ 331,000	$ (133,000)

The annual required contribution for the current year was determined as part of the January 1, 2009 and January 1, 2008 actuarial valuations using the entry age actuarial cost method. The actuarial assumptions include (a) 8.0% investment rate of return (net of administrative expenses) and (b) post- retirement benefit increases of 2.0% per year. Both assumptions included an inflation component of 2.0%. The actuarial value of assets for both valuations was determined using market value adjusted to recognize market value gains and losses over five years. The unfunded actuarial accrued liability is amortized using the level dollar method on a closed basis. The remaining equivalent single amortization period at December 31, 2008 was 15 years.

The following table summarizes the net pension obligation ("NPO") for the District's pension plan:

Fiscal Year Ending December 31,	Beginning of Year NPO (a)	Annual Pension Cost (b)	Actual Contribution (c)	Increase (Decrease) in NPO (b-c)	End of Year NPO (Prepaid Pension Cost) ((a)+(b-c)
2007	(294,579)	69,365	-	69,365	(225,214)
2008	(225,214)	91,994	-	91,994	(133,220)
2009	(133,220)	464,590	-	464,590	331,370

Analysis of Funding Progress - Pension Plan – The following table summarizes the funding status of the District's pension plan:

Actuarial Valuation Date December 31,	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) - Entry Age (b)	Unfunded AAL (UAAL) (b-a)	Funded Ratio (a/b)	Covered Payroll (c)	UAAL as a Percentage Of Covered Payroll ((b-a)/c)
2007	9,863,000	10,646,000	783,000	92.6%	N/A	N/A
2008	6,536,000	10,791,000	4,255,000	60.6%	N/A	N/A
2009	6,626,000	10,726,000	4,100,000	61.8%	N/A	N/A

NOTE 10 – COMMITMENTS AND CONTINGENCIES

Litigation – The District may from time-to-time be involved in litigation and regulatory investigations, which arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters existing as of December 31, 2009 will be resolved without material adverse effect on the District's future financial position, results from operations or cash flows.

Lease Commitments – The District is obligated for land and office rental under the terms of various noncancelable operating lease agreements. These expire in various years through June 2015. Following is a schedule by year of future minimum lease payments under operating leases as of December 31, 2009:

	Operating Lease Commitments	Lease Income	Net Lease Benefit (expense)
2010	$ 243,000	$ 233,000	$ 10,000
2011	293,000	279,000	14,000
2012	251,000	279,000	(28,000)
2013	256,000	279,000	(23,000)
2014	261,000	279,000	(18,000)
Thereafter	132,000	47,000	85,000
	$ 1,436,000	$ 1,396,000	$ 40,000

Total rental expense in 2009 and 2008 for all operating leases was approximately $1,178,000 and $1,069,000, respectively.

Regulatory Environment – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. The District is subject to routine surveys and reviews by federal, state and local regulatory authorities. The District has also received inquiries from healthcare regulatory authorities regarding its compliance with laws and regulations. Although the District management is not aware of any violations of laws and regulations, it has received corrective action requests as a result of completed and on going surveys from applicable regulatory authorities. Management continually works in a timely manner to implement operational changes and procedures to address all corrective action requests from regulatory authorities. Breaches of these laws and regulations and non-compliance with survey corrective action requests could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Hospital Seismic Safety Act – The District HAZUS reassessment application was submitted to OSHPD on June 16th, 2009. Final seismic evaluation information is scheduled to be submitted to OSHPD by the District's architect on May 1, 2010. Results of the seismic evaluation are expected to be submitted to DMC by OSHPD by July 1, 2010. The District has engaged an engineering firm to assess the building and develop a seismic compliance plan.

NOTE 11 – SUBSEQUENT EVENTS

Subsequent events are events or transactions that occur after the balance sheet date but before financial statements are available to be issued. The District recognizes in the financial statements the effects of all subsequent events that provides additional evidence about conditions that existed at the date of the balance sheet, including the estimates inherent in the process of preparing financial statements. The District's financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the balance sheet but arose after the balance sheet date and before financial statements are available to be issued.

The District has evaluated subsequent events through [redacted] which is the date the financial statements are issued.

WEST CONTRA COSTA HEALTHCARE DISTRICT

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

December 31, 2009

To the Board of Directors
West Contra Costa Healthcare District:

We have audited the financial statements of West Contra Costa Healthcare District (the "District") as of and for the year ended December 31, 2009, and have issued our report thereon dated _____. Professional standards require that we advise you of the following matters relating to our audit.

Our Responsibility under Auditing Standards Generally Accepted in the United States of America

As communicated in our engagement letter dated February 12, 2010, our responsibility, as described by professional standards, is to form and express an opinion about whether the financial statements that have been prepared by management with your oversight are presented fairly, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your respective responsibilities.

Our responsibility, as prescribed by professional standards, is to plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control over financial reporting. Accordingly, as part of our audit, we considered the internal control of the District solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control.

We are also responsible for communicating significant matters related to the audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Other Information in Documents Containing Audited Financial Statements

Pursuant to professional standards, our responsibility as auditors for other information in documents containing the District's audited financial statements does not extend beyond the financial information identified in the audit report, and we are not required to perform any procedures to corroborate such other information. However, in accordance with such standards, we have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information.

Our responsibility also includes communicating to you any information which we believe is a material misstatement of fact. Nothing came to our attention that caused us to believe that such information, or its manner of presentation, is materially inconsistent with the information, or manner of its presentation, appearing in the financial statements.

Planned Scope and Timing of the Audit

We conducted our audit consistent with the planned scope and timing we previously communicated to you.

Qualitative Aspects of the Organization's Significant Accounting Practices

Significant Accounting Policies

Management has the responsibility to select and use appropriate accounting policies. A summary of the significant accounting policies adopted by the District is included in Note 1 to the financial statements. During the year, the District adopted a Statement of Financial Accounting Standards regarding subsequent events as well as the Financial Accounting Standards Board's codification. There have been no other new accounting policies adopted and there were no changes in the application of existing policies during 2009. No matters have come to our attention that would require us, under professional standards, to inform you about (1) the methods used to account for significant unusual transactions and (2) the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

- The significant accounting policies adopted by the District are fully described in Note 1 to financial statements. There were no significant changes in accounting policies during the year. We had no disagreements with management concerning the accounting policies selected by the District or their applications.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's current judgments. Those judgments are normally based on knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ markedly from management's current judgments.

The process used by management in formulating particularly sensitive accounting estimates, and the basis for our conclusions regarding the reasonableness of those estimates primarily involved the following areas for the fiscal year ending December 31, 2009.

- Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts and determined that it is reasonable in relation to the financial statements taken as a whole.

- The District provides care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. A provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible. We evaluated the key factors and assumptions used to develop the provision for uncollectible accounts and determined that it is reasonable in relation to the financial statements taken as a whole.

- Management estimates of uninsured losses for professional liability, workers' compensation and employee health coverage have been accrued as liabilities in the accompanying financial statements. We evaluated the key factors and assumptions used to develop the actuarial estimates of uninsured losses for professional liabilities and workers' compensation and determined that they are reasonable in relation to the financial statements taken as a whole.

- The useful lives of fixed assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America.

Actual results could differ from these estimates. In accordance with accounting principles generally accepted in the United States of America, any change in these estimates is reflected in the financial statements in the year of change.

Financial Statement Disclosures

Certain financial statement disclosures involve significant judgment and are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the District's financial statements are the disclosure surrounding significant concentration of net patient accounts receivable and net patient service revenues.

Significant Difficulties Encountered During the Audit

We encountered no significant difficulties in dealing with management relating to the performance of the audit.

Uncorrected and Corrected Misstatements

For purposes of this communication, professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that we believe are trivial, and communicate them to the appropriate level of management.

The schedule below summarizes uncorrected financial statement misstatements whose effects, as determined by management, are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Passed adjustment # 1				
To remove the unsupported RAC reserve				
Dr.	RAC reserve liability		235,645.00	
Dr.	RAC reserve liability		869,524.00	
Dr.	RAC reserve liability		730,988.00	
Cr.		RAC reserve expense		1,836,157.00
Total			**1,836,157.00**	**1,836,157.00**

Passed adjustment # 2				
To adjust pension liability based on actuarial estimate				
Dr.	Net pension obligation		161,360.00	
Cr.		Pension cost		161,360.00
Total			**161,360.00**	**161,360.00**

In addition, professional standards require us to communicate to you all material, corrected misstatements that were brought to the attention of management as a result of our audit procedures. The schedule below summarizes corrected financial statement misstatements identified by us as a result of our audit procedures.

Adjusting Journal Entry # 1				
To adjust RN pension to supporting analysis				
Dr.	RN Pension expense		311,887.00	
Cr.		RN Pension Liability		250,377.00
Cr.		External Claims expense		61,510.00
Total			**311,887.00**	**311,887.00**

Adjusting Journal Entry # 2				
To correct ad valorem taxes and amounts due to the county				
Dr.	District tax revenues		447,927.00	
Cr.		County Loan		447,927.00
Total			**447,927.00**	**447,927.00**

Adjusting Journal Entry # 3				
To reclass credit balances in patient accounts receivable				
Dr.	Patient accounts receivable		4,627,923.00	
Cr.		Patient refunds		2,249,108.00
Cr.		Contractual adjustments		2,378,815.00
Total			**4,627,923.00**	**4,627,923.00**

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a matter, whether or not resolved to our satisfaction, concerning a financial accounting, reporting, or auditing matter, which could be significant to the District's financial statements or the auditor's report. No such disagreements arose during the course of the audit.

Representations Requested from Management

We have requested certain written representations from management, which are included in the attached letter dated _____.

Management's Consultations with Other Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters. Management informed us that, and to our knowledge, there were no consultations with other accountants regarding auditing and accounting matters.

Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and the District that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of the District within the meaning of professional standards.

Other Significant Findings or Issues

In the normal course of our professional association with the District, we generally discuss a variety of matters, including the application of accounting principles and auditing standards, business conditions affecting the District, and business plans and strategies that may affect the risks of material misstatement. None of the matters discussed resulted in a condition to our retention as the District's auditors.

This report is intended solely for the information and use of the Board of Directors and management of West Contra Costa Healthcare District and is not intended to be and should not be used by anyone other than these specified parties.

San Francisco, California

WEST CONTRA COSTA HEALTHCARE DISTRICT

Communication of

Internal Control Related Matters

December 31, 2009

COMMUNICATION OF INTERNAL CONTROL RELATED MATTERS

To the Management and Board of Directors of West Contra Costa Healthcare District

In planning and performing our audit of the financial statements of West Contra Costa Healthcare District (the "District") as of and for the year ended December 31, 2009, in accordance with auditing standards generally accepted in the United States of America, we considered the District's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be significant deficiencies or material weaknesses and therefore, there can be no assurance that all deficiencies, significant deficiencies, or material weaknesses have been identified. However, as discussed below, we identified certain deficiencies in internal control that we consider to be material weaknesses and other deficiencies that we consider to be significant deficiencies.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. We consider the following deficiencies in the District's internal control to be material weaknesses:

Net patient accounts receivable and revenues

Observation: During our audit we noted a significant amount of credit balances in the patient accounts receivable system. The credit balances had not been reclassified to current liabilities at year end.

Recommendation: We recommend that management review and revise their policies and procedures related to review of patient credit balances to ensure they are recorded as a liability in the financial close and reporting process.

Management response: *Management agrees with this recommendation. The accounts receivable process is critical to the success of any business. Management implemented many new processes and procedures to improve processing of patient accounts and to improve cash collections. Management's focus in 2009 was to improve the aging and to lower the self pay balances. These objectives were achieved in 2009. Improving the process for credit balances was a 2010 goal. These processes have been implemented in 2010.*

Observation: We noted during our audit an instance where the supporting medical records documentation related to a pharmacy charge that had been billed and collected for medication ordered was not locatable.

Recommendation: Moss Adams recommends that management review and revise their policies and procedures to ensure proper supporting medical records documentation is retained and easily locatable for all billed charges and for periodic audits that are performed to detect potential errors.

Management response: *Management agrees with this recommendation. Management has also recently completed an outpatient medical record audit. The results are expected by the end of April. Once the results are received, the district's revenue cycle committee will develop action plan to review and implement the audit recommendations. Management is currently working with the outside auditor to perform an inpatient audit in 2010. The same follow up process will be followed for the inpatient audit as is planned for the outpatient audit.*

Payroll cycle

Observation: During our audit we noted that supporting documentation of certain approved pay rates were not locatable. Also, certain of the pay rates did not agree to the supporting union contract or management pay rate matrices.

Recommendation: We recommend that management review and revise current policies and procedures to ensure pay rate approvals and supporting pay rate documentation is retained in each employee's file and easily accessible by management. Management should also ensure that current pay rates are supported by union contracts or other related pay scale documentation.

Management response: *Management agrees with this recommendation. Management has hired the human resource consulting firm of Integrated Network Inc. to perform an assessment of the human resource operations, including this process. The review will be April 28 and 29th. Their report will be issues approximately 4 to 6 weeks after the end of their review. Management will review and implement the report findings. Management is also currently in the process of revising its payroll system to address these system issues. The upgrade will be completed by June 30, 2010.*

Observation: During our audit we noted that gross payroll was not properly calculated by the payroll system, which has resulted in certain over and underpayments related to over time hours during the year.

Recommendation: We recommend that management review and revise current policies and procedures related to the payroll system to ensure the payroll system accurately calculates gross pay on a consistent basis.

Management response: *Management agrees with this recommendation. Management has hired the human resource consulting firm of Integrated Network Inc. to perform an assessment of the human resource operations, including this process. The review will be April 28 and 29th. Their report will be issues approximately 4 to 6 weeks after the end of their review. Management will review and implement the report findings. Management is also currently in the process of revising its payroll system to address these system issues. The upgrade will be completed by June 30, 2010.*

System access related matters

Observation: We noted during our audit certain instances where employees had access to certain systems or modules within systems that did not support the proper segregation of duties based on their roles and responsibilities. Some of the instances noted included users with access to billing functions and capabilities to modify bills, users with access to cash posting and access capabilities to post adjustments to patient accounts, users with editing access to the Human Resources system outside of the Human Resources department, as well as users outside the accounts payable department with access to accounts payable module.

We were unable to determine, if the Healthcare District has adequate segregation of duties to protect the integrity of network access, financial data access, and changes to technology systems. It appears that network access approval and implementation is completed by the network team and financial data access approval and implementation is completed by the finance team. To ensure appropriate duty segregation, there must be a separation and monitoring of change approval and completion of the work. The concept of segregation of duties is that no one person should have full administrative access to a particular system and be in a position to compromise the system.

Recommendation: We recommend that management review and revise current policies and procedures to ensure proper segregation of duties is adhered to when assigning system access rights to employees. We also recommend that management review assignment of its technology duties and, if not already in place, ensure that two-person control is implemented so that each employee can audit the work of another.

Management response: *Management agrees with this recommendation. The director of Information Technology and the Chie Financial Officer are reviewing this process and will implement the necessary controls and processes to completely implement this recommendation. The individuals whom had improper access have had that access removed.*

A significant deficiency is a deficiency, or combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the following deficiencies in the District's internal control to be significant deficiencies:

Accounts payable

Observation: During our audit we noted certain internal control policies that were established during the bankruptcy proceedings that are no longer being consistently followed, such as approvals on invoices, contracts and purchase orders. The following instances were noted:

Observation: Additional live signatures were not consistently included on check disbursements over $100,000, as outlined in the District's approval policy.

Observation: Purchase orders over $10,000 are not consistently being approved by the CFO, as outlined in the District's approval policy.

Observation: No dual approval or review process is in place for wire disbursements as processed by the Controller.

Observation: No formal policy was in place that would document permissible overrides to existing policies and procedures.

Recommendation: We recommend that management review and revise their policies and procedures to ensure the District's accounts payable approval policies are being updated and consistently followed.

Management response: *Management agrees with this recommendation. Finance management will review and revise when appropriate the policies and procedures. The event noted by the audit occurred prior to the appointment of the CFO. The accounting and accounts payable staff have had re-education on the policy for 2 signatures for checks over $100,000. The district's computer system was*

not set up to have purchase orders approved electronically. Management has implemented the process of obtaining CFO approval on all orders over $10,000. Management is currently investigating a new facility computer system, if that system is implemented it will have an electronic approval process installed and implemented. Management has implemented the process that the CFO approves all electronic transfers. This process has been set up within the last several months. The CFO executive assistant maintains the supporting documentation.

Financial close and reporting cycle

Observation: We noted during our audit that monthly account reconciliations were not reviewed consistently and in a timely manner during the year.

Observation: We noted during our audit that certain account reconciliations and analyses did not reconcile to supporting documents which in some instances resulted in audit adjustments, such as for the medical pension accrual and the loan due to the County based on estimated ad valorem tax revenues.

Observation: We noted during our audit an instance where a capital lease had been improperly classified as an operating lease due to in correct lease terms used in the provided analysis not agreeing to the supporting contracts.

Observation: We noted during our audit that journal entries posted did not consistently have supporting documents or indication of approval.

Observation: We noted during our audit that amounts in assets limited as to use were not properly broken out in their short term and long term portions for financial statement presentation purposes.

Observation: We noted during our audit that net pension obligation at December 31, 2009 did not reconcile to the supporting actuarial report. This resulted in a passed audit adjustment.

Recommendation: We recommend that management review and revise their financial close and reporting policies and procedures to ensure monthly account reconciliations are performed properly and reviewed in a timely manner, journal entries posted have supporting documents and indication or review and approval and necessary month end and year end journal entries are identified and recorded.

Management response: *Management agrees with this recommendation. The accounting staff have been instructed to reconcile each balance sheet account on a monthly basis and to maintain appropriate documentation to support the balance in each account. Management has implemented an approval process for all journal entries by the appropriate level of management. This process was implemented for the March 2010 close process. This recommendation has been implemented.*

West Contra Costa Healthcare District's written responses to the material weaknesses and significant deficiencies identified in our audit were not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on them.

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We believe the following operational or administrative recommendations may be of potential benefit to the District.

Net patient service revenue

Observation: We noted during our audit that census information was not periodically reconciled to the revenue reports and there appeared to be no formal review process to ensure proper revenue cutoff is observed at month and year end.

Recommendation: We recommend that management review and revise their policies and procedures to ensure proper revenue cutoff is observed for each reporting period.

Management response: *Management agrees with this recommendation. Policies and procedures will be revised and incorporated into the monthly close process by the June 2010 close.*

Cash management

Observation: We noted during our audit that signature cards were not available for all bank accounts and it is unclear if all past management members have been properly removed as signatories.

Recommendation: We recommends that management review and revise their policies and procedures to ensure terminated management members are removed from all bank account signatories in a timely manner. We also recommend that management retain all appropriate administrative documents in a secure location.

Management response: *Management agrees with this recommendation. The bank cards that were not updated were for Bank of America. The cards for Citibank and Mechanics Bank were updated at the September Board meeting. Bank of America signature cards were not updated for the new CFO because the district was converting its banking business from Bank of America to Citibank. That transition has taken longer than anticipated. All business with Bank of America should be transitioned to Citibank by the end of April. The CFO does review and approve all transactions with Bank of America.*

Accounts payable

Observation: We noted during our audit that no consistent and timely review of general ledger coding over accounts payable disbursements was noted.

Recommendation: We recommend that management review and revise their policies and procedures to ensure a periodic review of the general ledger coding by appropriate personnel is performed.

Management response: *Management agrees with this recommendation. Policies and procedures will be updated by June 30, 2010.*

Payroll cycle

Observation: We noted during our audit that certain instances were noted with no manager approval on employees' timesheets. Instead timesheets were approved either by an individual in the payroll department or the actual timekeeper.

Observation: We noted during our audit that manual payroll checks did not show an additional level of approval other than system generated signature on the checks.

Recommendation: We recommend that management review and revise their policies and procedures to ensure proper levels of approval over timecards and manual payroll checks.

Management response: *Management agrees with this recommendation. Education will be provided to the management team on the importance of appropriate of proper review and approval. Nursing Administration has implemented daily timesheet reconciliation with manager review and approval. We believe that this will increase the management accountability on this process and decrease the volume of manual checks. The payroll policies and procedures were updated and implemented in April. As of April 8, 2010 the CFO will approve all manual checks.*

Fixed assets

Observation: We noted during our audit certain instances were noted where fixed assets disposal forms and related gain/loss calculations were missing an indication of the necessary CFO approvals. Similarly, certain fixed

assets additions during the year did not have the proper supporting documents indicating approvals from the Boar per the capitalization policy.

Recommendation: We recommend that management review and revise their policies and procedures to ensure fixed assets are inventoried periodically and proper review and approval policies are being enforced by respective personnel.

Management response: *Management agrees with this recommendation. The items noted in the audit were prior to the appointment of the new CFO. Education has been provided to the accounting staff and this matter has been resolved.*

Inventory

Observation: During our observation of the inventory counts, the following matters came to our attention. Inventory was in use during counts and not always clearly marked. Detailed inventory listings with inventory quantities and extended pricing were not printed for all departments during and after the inventory counts. We noted a certain variances between our test counts and the District's counts performed that remained uncorrected.

Observation: No adjustment was recorded to update inventory balances at 12/31/09 from the counts performed at 12/18/09.

Recommendation: We recommend that management review and revise their policies and procedures to ensure periodic inventory counts are being performed in accordance with the District's policies and procedures, noted variances are corrected in a timely manner and inventory counts are adjusted as needed

Management response: *Management agrees with this recommendation. The appropriate policies and procedures will be revised by June 30, 2010.*

Information technology related matters

The Healthcare District has protected its technology systems with logical access controls at the level of individual users. However, the access controls were not tested during the year. Without testing of the financial application and network security access controls, the Healthcare District cannot be assured that unauthorized individuals are not accessing, reading, or even changing proprietary financial data. All network and system access controls should be tested periodically to ensure that unauthorized users are not allowed access and that different types of authorized users have their access appropriately restricted.

This communication is intended solely for the information and use of management, the Board of Directors, and others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

Sign as "Moss Adams LLP"

Date